FOR ARGUMENT.

Supreme Court, U. S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1978

No. 77-1715

SECRETARY OF PUBLIC WELFARE
of Pennsylvania, et al.,

Appellants,

v.

INSTITUTIONALIZED JUVENILES in
Pennsylvania institutions for the mentally ill
and mentally retarded, et al.,

Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

BRIEF FOR APPELLEES

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1978

No. 77-1715

SECRETARY OF PUBLIC WELFARE
of Pennsylvania, et al.,

Appellants,

v.

INSTITUTIONALIZED JUVENILES in
Pennsylvania institutions for the mentally ill
and mentally retarded, et al.,

Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

BRIEF FOR APPELLEES

QUESTIONS PRESENTED

1. Mental institutionalization results in severe deprivation of liberty, social stigma, self-stigmatization and discrimination. Are young persons entitled to substantial Fourteenth Amendment due process procedural protections prior to involuntary indeter-

minate mental institutionalization upon parental application? If so, what process is due?

2. With reference to state-licensed facilities, is "State action" present for Fourteenth Amendment purposes where the State delegates to private entities a power not possessed by the State, the power to deprive persons of liberty without minimal due process protections, and, alternatively, is "State action" present where mental commitment in Pennsylvania is a power traditionally exclusively reserved to the state from the earliest colonial period continuously to the present?

3. Did the District Court abuse its discretion in certifying two plaintiff subclasses and a defendant class, where each shares essential legal and factual characteristics and where the requirements of Rule 23, F. R. Civ. Pro., are met?

4. Did the District Court err in requiring the defendants to assure that the plaintiff class members, committed to institutions unconstitutionally, receive constitutional state procedures in a state forum to determine whether they are mentally disabled and in need of institutionalization?

STATEMENT OF THE CASE

I. *Original Proceeding*

On November 16, 1972, plaintiffs in this class action filed their complaint against state officials[1] challenging

[1]The defendants included the Secretary of the Department of Public Welfare which "has the power and duty to enforce" the state mental health law, to "make all regulations necessary and *(continued)*

those portions of Pennsylvania mental commitment statutes which permit the involuntary indeterminate confinement of juveniles without substantial procedural safeguards including notice, counsel and opportunity for hearing.[2]

A three-judge court was convened pursuant to 28 U.S.C. §§2281, 2284 and, prior to trial, extensive factual stipulations were entered into. At a three day hearing before the three judges, the testimony of six expert psychiatrists was heard. The depositions of three other psychiatrists were entered into evidence.

The named plaintiffs were confined at Haverford State Hospital under the challenged statutes (133a-

(footnote continued from preceding page)
appropriate," and to "operate and assign functions to all state facilities" and the Deputy Secretary for Mental Health and Mental Retardation (277a). The superintendent of Haverford State Hospital, who is responsible for receiving applications for admission, commitment and release under the challenged statutes, was "sued as representative of the directors of all mental health facilities in Pennsylvania," all of which are under the authority of the defendants Secretary and Deputy Secretary (275a). All mental institutions in the state, state-owned or state-licensed, are required by law to utilize the commitment statutes and regulations. 50 P.S. §4102. Department of Public Welfare Regulations, Title 9100 (291a).

[2]The defendants agreed to the District Court's suggestion that a guardian ad litem be appointed for the plaintiffs pursuant to Rule 17(c) of the Federal Rules of Civil Procedure: "With regard to the technicality involved, I am really at the court's pleasure. I really do not object to the going through with Mr. Ferleger as a next friend." (250a). As here, federal courts uniformly exercise their power under Rule 17(c) to protect minor litigants' interests where potential for parent-child conflict is present. *E.g., Roberts v. Ohio Casualty Insurance Co.*, 256 F.2d 35 (5th Cir. 1958).

134a).[3] They were detained after a psychiatric examination which lasted "anywhere from an hour to three quarters of an hour" (47a) "or shorter." *Id.* The reasons for admission of these persons (as stated by the hospital) included truancy, incorrigibility, homicidal and suicidal behavior, chaotic family, talking incoherently, rebellion, aggressive behavior, threats and assaults to family members, temper tantrums, sexual acting out, foul language, drug use and hallucinations (135a-165a). Treatment for the group included drugs, individual, group and family therapies, confinement to closed locked units, schooling and confinement in seclusion rooms. *Id.*

Information regarding the mental institutionalization of all juveniles in Pennsylvania facilities was provided to the District Court (310a-316a).[4]

The facts in the following numbered paragraphs are stipulated by the defendants:[5]

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[3]Children at Haverford State Hospital are held as civil "voluntary patients in the same treatment unit as those on criminal commitments." *See* Deposition of Barbara Armstrong (38a *et seq.*, 135a-165a).

[4]This information was provided in response to a discovery questionnaire which requested reports of the "reason" or "precipitating behavior" for commitment (27a, 773a). The extensive data are collated and summarized at 210a *et seq.*

[5]The stipulation and admission of these facts (522a-523a) was preceded by defendants' objection that additional data from the juveniles' medical records should be before the court (288a). To satisfy this objection, the court and the parties agreed that the records of ten randomly selected juveniles could be introduced into evidence (317a-363a). The random selections confirmed the representativeness and accuracy of the summaries given by the institution of the reasons for commitment. *See, e.g.*, the case in note 7, *infra*.

1. Children have been institutionalized in Pennsylvania mental health facilities for the following reasons as noted by the institution: "Runaway, incorrigible," "Violent episodes," "Hostile, attacked children, attempted to set home on fire," "Robbed gas station," "Stole truck, car," "Member of gang which participated in robbery," "Delinquent behavior," "Arson," "Runaway," "Runaway, truancy, delinquent behavior."

2. Mental institutions sometimes cooperate with parents and relatives "farming out their kindred into mental institutions for motives not always worthy."[6]

3. Children have wound up at institutions for the retarded for the following reasons, in addition to retardation:

> "Interim placement while family was on vacation."[7]
>
> A mother placed her child because "father out of household in the military."
>
> "Hyperactivity interfered with the routine of household and disturbed family members."
>
> "An institution accepted a child from a mother because of "desertion of father."

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[6]*Kent v. United States*, 401 F.2d 408, 416, n. 4 (D.C.Cir. 1968) (Burger, J., dissenting).

[7]More than ten months after this "vacation," this individual was reported still at the institution for the retarded; he was committed on July 20, 1972 for what his parents told the facility would be a one or two week stay. The facility reported the individual still committed as of May 31, 1973 (355a-362a, 773a). The District Court's reference to this case, 790a, is criticized by the defendants who, erroneously and *contra* the record, claim that this commitment was part of a state "respite care" program. Brief for Appellants at 46, n. 40.

Also, "Family conflicts," "Unmanageable at home, attitude of bold indifference, resents all discipline, compulsive eating," "Runaway, conflict with parents," "Neglect, Social Deprivation," "Neglect, unstable home environment," "No serious behavior problem; admitted due to parents' inability to provide a satisfactory home environment," "Sometimes hyperactive. Illegitimate," "Illegitimate. Inadequate mother."

4. One facility accepted a young retarded boy because "He has no playmates, planned activities, exercise. Presently he does nothing except sit in school and in front of the T.V. at home."

5. Three juveniles were committed to mental institutions because of physical ailments: ulcerated colitis, a psychosomatic complaint, weight loss.

6. Five juveniles were reported in one facility for not going to school.

7. A number of juveniles are committed for alleged drug-related activities.

Judgment was entered in favor of the plaintiffs,[8] the defendants appealed and this Court noted probable jurisdiction. While the appeal was pending, the Pennsylvania legislature enacted the Mental Health Procedures Act, 50 P.S. §7101 *et seq.* (hereafter, the "1976 Act") which altered commitment procedures for persons alleged to be mentally ill. In view of the effects of this statutory change, this Court held that the class action originally approved no longer met the requirements of Rule 23(a) and vacated and remanded "for consideration of the class definition, exclusion of

[8]Because important changes were made by the District Court after remand, the 1975 opinion and order (783a *et seq.*, 843a *et seq.*) are not summarized at this point.

those whose claims are moot, and substitution of class representatives with live claims." *Kremens v. Bartley*, 431 U.S. 119, 135 (1977).

II. *Procedural History on Remand*

On remand, plaintiffs filed an amended and supplemental complaint (875a *et seq.*). Nine of the twelve named plaintiffs included every juvenile committed as mentally ill under the 1976 Act to Haverford State Hospital at the time of filing (945a). Three of the plaintiffs were committed as mentally retarded to other institutions under the 1966 Act, 50 P.S. 4101 *et seq.*[9]

As in the initial proceedings, a defendant class of all Pennsylvania facility directors was sued, as was the Secretary of Public Welfare.[10] Unlike some states, mental health facilities in Pennsylvania are not merely licensed to provide services; they "have been required and are required to utilize and act in conformity with the commitment and admission procedures in both the 1966 Act and the 1976 Act." (949a). When institutionalized juveniles object to their confinement, the defendant facility directors, relying on the state law,

[9]The defendants again agreed to the maintenance of the litigation by the guardian ad litem, at no point raising any objection to single counsel functioning in that capacity. *See* 945a. Defendants did attempt to restrict the guardian's access to his clients and their records. On motion, the District Court ordered the defendants to permit full access to medical records, institutional living areas and the plaintiff class members themselves. Orders of June 21, 1977 and July 25, 1977. On the guardian ad litem's functions, see 1073a-1074a, n. 39 and 40.

[10]*See* note 1, *supra*.

"do not provide counsel or take action to assure either discharge or a hearing on the juvenile's objection. . . ." (950a). A defendant class was certified.[11]

The District Court set March 31, 1978 for the final hearing on the merits and ordered the parties to advise the court whether additional evidence would be submitted. Plaintiffs offered to submit expert testimony on "possible differing considerations between the young and very young and between those persons alleged to be mentally ill and retarded." (960a, citing 431 U.S. 119, 135). The defendants offered to produce no testimony.

Welcoming such expert testimony on questions raised by this Court, the District Court directed that it be presented by deposition.[12] Plaintiffs took the deposition of the Assistant Commissioner for Mental Retardation for the Department of Mental Health, Commonwealth of Massachusetts (972a *et seq.*). The defendants provided no expert testimony, or any factual testimony whatsoever.[13] The Commissioner's testimony stood uncontradicted.

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[11]For the District Court's memorandum and order on this issue, *see* 956a *et seq.* Counsel for several state-licensed facilities who were present at the final hearing made no objection, then or at any time, to the all-inclusive class definition and did not seek to present any evidence. Hearing of March 31, 1978.

[12]Hearing of March 31, 1978.

[13]Throughout their brief, defendants repeatedly make "factual" assertions regarding the differences between the young and very young and the mentally ill and the mentally retarded. These assertions, which bear no references to the record, are not based on any evidence in the case. In fact, the only evidence on these matters after remand is the expert testimony cited in the text.

At the final hearing, an extensive factual stipulation was entered into evidence (943a *et seq.*) as were portions of the named plaintiffs' medical records. The court accepted the parties' agreement to include in the evidence on remand "all testimony, depositions, exhibits, interrogatories, objections and rulings" from the original proceedings (950a, 1066a, n. 17).

III. *The Haverford State Hospital Plaintiffs*

The score of buildings at Haverford State Hospital, located in a rural/suburban area outside Philadelphia, include Building 14, a structure with two large wards. The west ward houses geriatric patients; the door to it is generally unlocked. The east ward houses juveniles (948a).

Entry into the children's ward is through a locked door bearing a sign which reads, "VISITING HOURS—1:30-4:30 Weekends and Holidays. No evening visits." (948a).

The ward consists of two hallways which cross at a glass-walled nursing station. One hallway continues from the entrance door to a large dormitory area for male patients. Along that hallway are two carpeted unfurnished rooms used for "seclusion" or "time-out" purposes. The second hall has a large dayroom at one end and, at the other end, a large dormitory area for female patients (949a).

In the nursing station is a bank of television monitors which is used to surveil the patients in all areas of the unit, including the halls and dormitories (949a). A week before the final hearing, the monitors in the dormitory area were switched off (Oral stipulation at

March 31, 1978 Hearing). Adjacent to the building are playing areas fenced in by chain link fences about 12 feet high (949a).

The named plaintiffs at Haverford ranged in age from 7 to 13 years. A county child care agency was involved in three of the nine commitments.[14] All were committed to the institution simply upon the application of a parent or guardian and its acceptance by the institution pursuant to Section 201 of the 1976 Act. There is nothing in the record to indicate that anything more than Haverford's typically brief psychiatric examination by a staff doctor preceded these commitments. *See* Deposition of Barbara Armstrong at 47a, 1059a, n. 11, 1061a, n. 15. The admission process includes a pre-admission contact or interview with a social worker and other staff (this may be the same day as admission) and an interview of the child by a psychiatrist, recorded in an admission note on the day of admission. The admission note summarizes the factual and psychiatric basis thought to justify the commitment.[15]

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[14]Thus, the defendants are in error when they state that "[i]n this case each of the appellees' parents sought medical help. . . ." Brief for Appellants at 30. For the entire class, the record indicates about 15% are not committed by their parents (933a, 952a at par. 45).

[15]Paragraph 37 of the Complaint, 884a, admitted by the defendants at 919a. The single or multiple "independent" examinations the defendants claim are required and provided, Brief for Appellants at 44, are not part of the procedure.

Although defendants were given the opportunity to demonstrate that referral material was used in deciding whether to confine the plaintiffs, the District Court found that "there is still

(continued)

These admissions notes, and the circumstances of the named plaintiffs, illustrate the great range of disputed behavior and facts surrounding the commitments and the unstable and conflict-ridden family situations of these young persons.[16]

Kevin S.

Kevin's mother, who is separated from his father, has a history of serious mental illness, including suicide attempts and hospitalizations. She was institutionalized when Kevin's elder brother was born. When pregnant with Kevin, she returned to the institution and, she admitted to Haverford State Hospital staff, "lied" to get in again.

At home with his mother, Kevin was physically abused. Most of his early life was spent in foster homes.

At the age of 12, Kevin was brought to Haverford State Hospital by the county child care agency and his

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(footnote continued from preceding page)

little evidence showing in what way, if at all, these records were used during the admissions process." (1061a, n. 15).

State procedures allow the most extreme summary commitment "process." As the District Court described the experience of one of the named plaintiffs:

> Hospital records show that Edward was not informed that he was to be admitted to a mental health facility prior to his admission date, but rather was told that his parents were taking him to a new school. He was extremely upset by the admission process, expressing fears about being in a hospital with "crazies" and being confined "like a prisoner."

1064a. In another case, the admission form for Francis B. was signed in blank. Defendants' Exhibit 9.

[16]The descriptions in the text are from the opinion of the lower court (1062a-1065a), supplemented by the medical records in evidence (Defendants' Exhibits 1 through 12) and the defendants' answer to the complaint (916a *et seq.*).

mother and was committed under Section 201 of the 1976 Act. After he was admitted, a psychiatrist interviewed Kevin and prepared an admission note which gives as the "reason for admission:" "Difficulties adjusting to school and family (mother). Exhibited bizarre behavior in school that has included making inappropriate sounds and laughing inappropriately." There is no indication in the records of Kevin's admission that he was ever asked for his comments or version of the behaviors he was accused of.

Haverford's psychosocial history of this plaintiff notes that his mother actively uses social systems "to the point of abuse" and concludes:

> It is felt that much of Kevin's problems come from living with a schizophrenic mother and having a very unstable and abused early life.

Richard S.

The county child care agency committed Richard S. to Haverford under Section 201 of the 1976 Act when he was 12.

Richard S. did not live with his mother until he was two years old and he stayed with her only until he was four when he was placed in an agency's children's cottage, later to be cared for in other homes for children.

The first psychiatric evaluation recorded for Richard S. in the hospital records was made the day of his admission and gives as the "reason for admission:" "Inability to adjust to open setting. History of self harm and running away." This evaluation contains no indication of whether Richard S. was given any opportunity to respond to the alleged basis for his institutionalization.

James Paul M.; Edward B.; Raymond C.

At age 7, James Paul M. was committed to Haverford by his father. His mother had died about one year before. The admission note gives "Uncontrollable behavior. Learning disability" as the reason for admission, with no further detail.

Plaintiff Edward B. was referred to Haverford by his private psychiatrist, Dr. Carl Hammer, who, it happens, is also a part-time psychiatrist at the institution. Edward is an adopted child.

Pursuant to Section 201 of the 1976 Act, Edward's parents signed him into the institution, having admittedly tricked him into accompanying them. The admission note records the extent to which his parents' actions and the hospital's procedures traumatized the 11 year old:

> Eddie then opened up with many feelings about being tricked into coming by his parents. He expressed feelings about them not caring for him and wanting to get rid of him. Both parents acknowledge that they had "tricked him" because they were fearful he would hurt or threaten to hurt himself. They admitted that they had not told him until that morning and had omitted the fact that this was a psychiatric hospital. Eddie's response to this was to make promises that he would change if he could stay home. * * * Eddie continued with his fears of being in a "crazy" hospital and of getting hurt by other patients—both adults and children. He also spoke of the high fences and of being kept in, like a prisoner.

Raymond C. was committed to the institution the day he was first seen at the facility. Under Section 201 of the 1976 Act, he was committed by his father who

had a drinking problem, according to the hospital's records. Institutionalized for "evaluation" initially, the admission note states the "reason for admission" as "History of uncooperative behavior including run away from school. Problems in community with stealing and destroying property. Has a learning and hearing problem."

William B.; Francis B.

Committed to the institution under Section 201 at the age of 9, William B. had been born to parents who separated when he was an infant. Two years prior to the commitment, William began living with his father in a home with a stepmother and two stepbrothers.

The reasons given by the institution for his commitment were "Uncontrollable behavior; preoccupied with matches, set a rug on fire, turned the gas burners on in the house, throws things out the window."

According to the hospital records, William B.'s life with family members subjected him to situation of extreme inconsistency, disorganization and lack of structure. His natural mother's lifestyle was erratic and she reportedly abused him.

Francis B. was about 9 when he was committed to Haverford, originally under Section 403 of the 1966 Act. This admission was at the request of his father who signed admission forms which omitted the proposed patient's full name and any identifying information. Francis' father later executed a commitment under Section 201 of the 1976 Act.

This young plaintiff comes from a disorganized family which has rejected him. As a social history a month before his confinement observes, "One of the

most distressing aspects of this case is the almost total rejection of Frankie by everyone in his family." His father has a drinking problem, the records indicate that the "parents are in need of help also as there is some question here of physical abuse" and, at the pre-admission interview, it was apparent that "Frank could no[t] do right in parents' eyes."

The admission note contains unamplified allegations of "difficulties adjusting to school" and states that Francis B. "has been described as hyperactive . . . clowning in order to get attention." A psychiatric evaluation received by the institution in referral material states, "I cannot describe him as hyperactive. In the first interview his mother seemed more hyperactive than he did."

Maria L.; Thomas W.

Maria L. was committed to the institution by her mother at the age of 11 pursuant to Section 201 of the 1976 Act. The "reason for admission" was stated by the psychiatrist to be "Difficulties adjusting to school because of aggressive behavior. Difficulties adjusting within the family."

Relationships between Maria and her parents are strained in several ways. She is the third of four children and Haverford's psychosocial history reports that

> The youngest is given special attention by Mr. L___ because Mrs. L___'s pregnancy with him kept her from divorcing Mr. L___. Mr. L___ does not want to assume any responsibility in raising the children or helping with home chores. He formerly spent a great deal of time away from

home, usually drinking, but now stays at home more, although he still drinks a good deal. Mrs. L___ does not see the drinking as a problem.

Maria's mother "has had near mental breakdown from the strain of the children" and, several times, tried to choke Maria, according to the same history of the case.

Thomas W.'s parents have an unstable marriage. After a severe beating which resulted in the child's hospitalization at the age of 9, Thomas' case came to the attention of social service agencies and his mother and stepfather were arrested.

The county child care agency, which has custody of Thomas W., committed him to Haverford from the County Juvenile Detention Center, first as an emergency commitment and then under Section 201 of the 1976 Act. While at the detention center, shortly before his commitment, he was given a psychiatric evaluation by John Fong, superintendent of Haverford, in his capacity as a "consultant." Haverford's stated "reason for admission" is "Fire setting, rages of 5-6 hours, during which he is assaultive, destructive and sets fires."

The Haverford State Hospital plaintiffs described above are not a selection from a larger group; every juvenile committed to Haverford under Section 201 at the time the suit was filed is included (945a). Also, absolutely none of the plaintiffs had ever been institutionalized before the commitments described above; it was their first time in the institution (910a, 924a).

IV. *Plaintiffs Committed Under the 1966 Act*

Pennhurst State School and Hospital is located in a rural area of Pennsylvania near Valley Forge. Built in the first decade of this century, it is unaccredited by the Joint Commission on the Accreditation of Hospitals.[17]

Plaintiff George S. was committed to Pennhurst under Section 402 of the 1966 Act by Catholic Social Services, an agency which was caring for him under contract with the Philadelphia Welfare Department which had legal custody of him. George was abandoned by his parents. From the first year of his birth until 6 years later (when he was committed to the institution), he lived with a foster family.

When his foster mother was hospitalized and, for a time, unable to care for George, he was placed in another foster home temporarily. Because of crowded conditions in that home, the placement was terminated; Catholic Social Services then signed George into Pennhurst.

Built in 1897, Polk State School and Hospital is located in a rural community about 80 miles from Pittsburgh. The remaining two plaintiffs are incarcerated at Polk.

At the age of 6, in 1967, the year her parents divorced, Gina S. was placed in a county infants' home. Three years later, she was removed by her mother and taken directly to Polk where she has remained since.

Gina S. was committed under a law, invalidated in 1971, which permitted any two doctors to certify the

[17]The shocking conditions and total lack of care at this institution are detailed in *Halderman v. Pennhurst State School and Hospital*, 446 F.Supp. 1295 (E.D. Pa. 1977).

indefinite commitment of any person.[18] No commitment papers were executed from 1971 until 1975 when the plaintiff's mother signed an application for commitment under Section 402 of the 1966 Act.

Nancy Louise D. was born in 1960. Both her parents were alcoholics and both were mentally retarded. In 1961, Nancy Louise was placed under the guardianship of the county welfare department which placed her in foster care until 1968 when she was taken to Polk.

"Her application form for admission shows that she was admitted under the authority of the Mental Health Act of 1951, rather than the 1966 Act then in effect." (Opinion at 1065a, n. 16). No commitment forms have ever been executed under the 1966 Act. Polk's director, however, purports to maintain her confinement under Section 402 of the 1966 Act.

George S., Gina S. and Nancy Louise D. are all mentally retarded to some degree. There is nothing in their medical records indicating that their mental condition required institutional care, rather than the non-institutional care they had been receiving prior to commitment.

V. *The District Court's Decision*

Holding that the plaintiffs' constitutional liberty interests are implicated by institutionalization, and that parents and guardians cannot waive young persons' constitutional rights, the District Court, with one judge dissenting, mandated certain due process

[18]Section 404 of the 1966 Act, 50 P.S. §4404. This statute was declared unconstitutional in 1971 in *Dixon v. Attorney General of the Commonwealth of Pennsylvania*, 325 F.Supp. 966 (M.D.Pa. 1971) (Three-Judge Court).

procedures to protect against erroneous commitments and to assure the least restrictive alternative form of care.

Brief descriptive reference to the District Court's decision is necessitated by the defendants' repeated misleading and deficient characterization of the judgment now before this Court. Defendants misconstrue the relief that was granted. Further, defendants totally ignore (and, significantly, do not challenge) the detailed factual findings below.

The District Court *did not order* that every child committed "be provided two separate adversary hearings." Brief for Appellants at 20. The District Court *did not order* "a court hearing to check the accuracy of the mother's reports or the doctor's diagnosis and recommended treatment. . . ." Brief for Appellants at 42. The District Court *did not order* procedures "to enhance the diagnostic process." Brief for Appellants at 45.

The only procedures absolutely required in every case are notice[19] and "counsel or other trained representative." (1093a). The court explained the need and function of the child advocate in this way:

> It may not always be necessary to appoint a lawyer so long as a substitute procedure adequately protects the child's interest. For example, it may be sufficient to appoint a guardian, trained in the

[19]Notice is not required prior to confinement in the institution. The order specifically declares that parents and guardians "may initiate the temporary detention" of young persons (1092a) and that a probable cause hearing need not be held for three days after the commitment (1094a). Notice must be received 48 hours before the hearing (1093a).

> mental health field, who would advocate the child's interests or alternatively, have the power to retain a lawyer to do so. The important point is that the child must have a capable advocate who has the sole responsibility of advancing the child's best interests. However, until alternative procedures are designed which will adequately protect the child's interests, we adhere to our conclusion that counsel is required.

Opinion at 1079a, n. 47. Once the juvenile and his or her representative has notice of an intention to prolong the institutionalization, the decision is made whether to waive or insist upon the hearings and further rights recognized by the court (*i.e.*, presence at hearing, confrontation, standard of proof). *See* 811a, n. 26 (original opinion), 1079a, n. 48 (current opinion), 1094a (current order).

Contrary to the defendants' claims, the District Court was crystal clear that "we neither intend nor expect that all of these procedures will be required every time an attempt to institutionalize a child is made." (811a, n. 26). In its recent memorandum on the motion to stay, the court noted the major likely practical effects of the flexibility inherent in the procedures:

> In fact, the witness who testified on behalf of the Devereaux Foundation stated that he believed that the majority, if not all, of the 300 class members at Devereaux are content and, given the choice, would choose to remain there. In the case of many of these juveniles, a hearing might be waived.

Memorandum of July 17, 1978 at 4.

Regarding the nature of the forum for hearings which are held, the lower court explicitly chose to "state only that the tribunal must be neutral and unbiased." (1082a). The state is left "free to develop its own safeguards (1079a) to protect plaintiffs' rights. The order does not decide "[w]hether the tribunal should be judicial or administrative." (1082a and *id.* at n. 53).

If a hearing occurs in a particular case, the neutral tribunal will determine the factual questions which arise inevitably. The decision-maker will resolve "whether, in fact, the child is mentally ill or mentally retarded. If this determination is affirmative, the tribunal should proceed to determine if commitment is necessary, if it will be beneficial to the child, and if it is the least restrictive alternative." (1081a). "While the tribunal should make findings to support its determination, these findings need not necessarily be made formally." *Id.*

On remand, the District Court refined and set forth the factual findings which are the foundation of its legal conclusions. The defendants have not challenged these factual findings on appeal. Some of the major findings of the court are summarized below:

> 1. A serious and injurious stigma attaches to institutional commitment whether the juvenile is classified as mentally ill or mentally retarded (1067a). This stigma may be "a more lasting abridgement of personal freedom than imprisonment for the commission of a crime." (795a).
>
> 2. Both mental illness and mental retardation (in part, for different reasons) are subject to error in diagnosis and identification (1067a-1068a) "substantially different from the treatment of other medical conditions." (1077a-1078a).

3. Conflicts between the interests of parents and juveniles frequently arise respecting commitment and parents often institutionalize their children for reasons unrelated to the young persons' needs and best interests (798a, 1068a-1069a).

4. Deprivation of liberty is inherent in institutionalization and its serious, isolating and dehumanizing effects which apply to both the mentally ill and mentally retarded, regardless of whether the institution is state-operated or state-licensed (1069a-1070a).

5. The dangers of misclassification and the stigma of institutionalization fall more heavily on the younger child.

6. With respect to the mentally retarded, the decision to institutionalize is often a long-term or even life decision (1078a, n. 45).

7. The effects of a hearing—on both children and parents—would not be traumatic but would be beneficial (1081a-1082a, detailing benefits).

8. Any potential trauma due to the hearing process can be avoided by waiver of the person's presence. Also, "any danger of trauma pales beside the potential severity of the deprivation of liberty suffered by a child needlessly institutionalized." (1082a).

9. Institutional staff have a conflict of interest in making decisions to commit (1083a-1084a).

The District Court entered judgment for the plaintiffs on May 25, 1978, granting declaratory and injunctive relief to assure that persons presently deprived of liberty under the invalidated statutes and persons who might be committed in the future receive the benefit of minimal due process procedures in a state-created forum. This appeal followed.

SUMMARY OF ARGUMENT

1. Mental institutions are generally underfinanced, understaffed and overcrowded. Commitment to such a residential facility necessarily entails a massive curtailment of liberty as persons are placed in a "total institution" in which every aspect of their lives is regulated by impersonal authority.

A powerful long-term effect on the individual's life reverberates long after release from the facility. Severe social stigma, self-stigmatization, job and license discrimination also result from the commitment to mental institutions for the mentally ill and the retarded. It is the fact of institutionalization, not the procedures used, which stigmatizes.

2. Mental commitment is generally considered a deprivation of liberty under the Fourteenth Amendment and the states are required to provide substantial procedures to protect persons from erroneous commitments. *O'Connor v. Donaldson*, 422 U.S. 563 (1975); *Baxstrom v. Herold*, 383 U.S. 197 (1966); *Specht v. Patterson*, 386 U.S. 605 (1967). *See also Chaloner v. Sherman*, 242 U.S. 455 (1917); *Dexter v. Hall*, 82 U.S. 9 (1872). The pervasive concern has been that no person may be caused to suffer a loss of liberty—for whatever reason—without stringent decision-making requirements designed to minimize the ever-present risk of error and to assure proper disposition of the case.

3. The defendants, invoking the "family's right of privacy" and "the sanctity of parental responsibility," maintain that a young person's constitutional right to liberty is not implicated at all in mental institutionali-

zation under parental commitment laws. This conclusion misconceives the applicable constitutional doctrine.

Two controlling principles emerge from the Court's decisions regarding parents and children. Where the state unreasonably intrudes into the family's domain and thereby jeopardizes the family's function and strength as the primary socialization mechanism, the state's intrusion will be struck down. *See Meyer v. Nebraska*, 262 U.S. 390 (1923); *Pierce v. Society of Sisters*, 268 U.S. 510 (1925); *Wisconsin v. Yoder*, 406 U.S. 205 (1971). In precisely parallel fashion, where parental decisions unreasonably jeopardize the young person's opportunities for growth into well-developed individuals, governmental intrusions into the family will be upheld. *Prince v. Massachusetts*, 32 U.S. 158 (1944); *Wisconsin v. Yoder, supra*.

The extent of control over juveniles by parents and guardians is broad enough to provide appropriate deference to the importance of the family but narrow enough to protect the independent personal interests of the most powerless of the family's members.

4. In other cases where constitutional rights of young persons have been at stake, but where family interests were not implicated, this Court has recognized minors' liberty claims, although the extent of such claims has been subject to possible limitation. *E.g., Erznoznik v. City of Jacksonville*, 422 U.S. 205 (1975); *Ingraham v. Wright*, 430 U.S. 651 (1977); *Carey v. Population Services International*, 431 U.S. 678 (1977).

One liberty interest of young persons which has repeatedly been identified by this Court as implicated

by the Fourteenth Amendment is the right to be free from physical confinement, for whatever purpose, in an institution. *See In re Gault*, 387 U.S. 1 (1967); *In re Winship*, 397 U.S. 358 (1970); *McKeiver v. Pennsylvania*, 403 U.S. 528 (1971); *Breed v. Jones*, 421 U.S. 519 (1975). *See also Giacco v. Pennsylvania*, 382 U.S. 399 (1966). A constitutional liberty interest is discerned even if the purpose of the confinement is "clinical" treatment or "to save the child." There is no suggestion in any decision of this Court that parental endorsement of a decision to separate the young person from the home and confine him or her in an institution nullifies the juvenile's Fourteenth Amendment rights.

5. As the lower court's unchallenged factual findings and the record in this litigation shout forth, applications for commitment of young persons are not the expression of calm, conflict-free, rational, informed, reliable parents and guardians. On the contrary, the expert witnesses for all parties agreed that families seeking commitment are characterized by severe stress, disharmony and dislocation. The family structure is weakened. Parents will seek to institutionalize children for improper reasons. This stems from honest mistakes, ignorance, lack of awareness of alternatives to institutionalization, lack of community resources, or sometimes from malice or ill will.

Parents are not particularly good observers of children's behavior and symptoms in the context of the high feelings that run in these situations. They cannot be objective reporters of the behavioral background of the child; they often exaggerate and misinterpret the actions of their children. When these family dynamics are viewed in the framework of the alleged behavior

which precipitates the request for commitment, conflicts between the concerns and interests of the parents and the best interests of the child are apparent.

6. Stereotypes regarding the retarded and their mental institutionalization are tragically hardened and erroneous. A person's level of retardation, for example, does not predetermine his or her need for institutionalization. Many factors are more important in determining institutionalization of retarded persons, including family disorganization, demographic characteristics, parental attitudes toward childrearing and mental retardation, availability of community resources, and the professional philosophies of those consulted for advice. Inappropriate and unneeded institutionalization is often the unintended result. The only evidence on the family situation of the retarded, the expert testimony for the plaintiffs by the head of retardation for the Commonwealth of Massachusetts, confirms the trying situation faced by such families and the fact (found by the lower court) that no identity of interests may be presumed, no matter how well-motivated the parents might be.

7. The legal test to be applied is found in *Planned Parenthood of Missouri v. Danforth*, 428 U.S. 52 (1976), where the Court examined "whether there is any significant state interest in conditioning an abortion on the consent of a parent or person in loco parentis that is not present in the case of an adult." A direct and persuasive response to *Danforth* is that the constitutional interest in freedom from physical confinement without due process admits of no exceptions applicable here and that no asserted state interest

in other juvenile cases has overcome this liberty, no matter how rehabilitative or treatment-oriented the institution of confinement has been.

8. Previous cases, however, have not involved a parent or guardian acting to assure confinement. The only interest asserted here by the state is parental autonomy expressed by medically-advised deprivation of a person's liberty. Such an argument was expressly rejected in *Danforth* where the "conflict" situation "has already fractured the family structure." As in *Danforth*, any parental right to obtain mental health care for a child is no more weighty than the liberty right of a child proposed for institutionalization. The parental interest cannot act as an absolute limitation on the child's right. *Danforth, supra; Bellotti v. Baird*, 428 U.S. 132 (1976). Under *Danforth*, a countervailing state interest must be established by more than the unsubstantiated declaration of its existence; here, the record provides no support for any claim that "parental autonomy" is preserved or protected by commitment of young persons to institutions without due process protections. Other possible rationales for differentiating between the rights of young persons and adults are neither asserted by the defendants nor present in this case.

9. The critical question raised by *Danforth* is not "when rights conflict, which are paramount?" but "when presumed common interests in fact diverge, how can each be accommodated and protected?" There is a continuum of decisions made by parents and guardians regarding their wards. At one end are constitutionally trivial and intra-familial issues in which there is little, if

any, potential harm to the child. Along the continuum, parental powers are met with limits as their interests and desires diverge from those of young persons, in whom the state has an interest. As the parents' claims threaten to risk or unduly interfere with the child's, the divergence becomes so great that the parents' assertion of rights is not permitted to overshadow the social necessity of protecting young persons' independent interests. When viewed in terms of its nature and potential for harm, mental institutionalization—whether the commitment is erroneous or not—is an event near the end of the continuum at a point where the "parental autonomy" claims are properly muted to the extent necessary to protect the "liberty" claims of the child who is being removed from the home and placed in an institution.

10. The involvement of psychiatrists, physicians or other professionals cannot act as a fail-safe in the commitment process. The field of psychiatry is beset with uncertainty of diagnosis and tentativeness of judgment. In addition to the factual disputes which crop up in every commitment, the very existence of mental illness and the need for institutional care are facts not amenable to purely medical termination. Institutional psychiatrists have multiple conflicts of interest in making commitment decisions. The situation is mirrored for mental retardation, although the reasons for mistakes in identifying the retarded are somewhat different (*e.g.*, confusion with physical characteristics, testing problems, incorrect developmental speculations). Parents of the retarded receive consultation from physicians which is typically

uninformed, without reasonable basis, and inappropriately and excessively oriented toward institutionalization. Professionals at retardation institutions and in the community are unable to make conflict-free referral recommendations or to sort out the inevitable factual disputes.

11. What process is due? The lower court's mandate is extremely narrow and limited. With the exception of notice of prolonged commitment and counsel or other trained representative, all rights may be waived, including presence at the hearings. It is expected that hearings will not be required in every case; a large number will be waived. The forum for any hearings which are held would be an "impartial tribunal" created by the state where the perspective and concerns of the parents or guardians could be fully aired. Many states already provide such hearings for young persons facing commitment.

12. The lower court found as a fact that any hearings would not be unduly traumatic for juveniles but would be beneficial, to the juvenile and his or her parents. The opportunity for hearings would result in agencies performing more effectively, the avoidance of many commitments, reduced use of institutionalization, and provision of more appropriate care in particular cases.

13. The requisites of due process found by the lower court to be appropriate are notice of prolonged commitment; counsel or other trained representative (for example, a guardian who would have the power to retain counsel, if legal assistance was required); a hearing before an impartial tribunal within a reasonable time after commitment (a probable cause hearing

after three days and, if necessary, a full hearing after two weeks); the right to be present; the right to confront and cross-examine witnesses and to present evidence; a clear and convincing standard of proof.

14. These procedures would significantly reduce the risk of error. They would also assure protection of the young person's right to care in the least restrictive alternative appropriate to the person's needs. The state has no significant interest in avoiding these procedures. Any cost is outweighed by the private interests and risk of error. Avoidance of institutional care and diversion of some cases to community-based programs will result in substantial cost savings to the state. The state has no interest in the erroneous or unnecessary confinement of any of its citizens, regardless of age.

15. The state statutes and regulations permitting parents to volunteer their children into mental institutions fail to protect the rights and interests of the plaintiffs. Referral systems and evaluations are faulty and provide a skimpy professionally unacceptable (and legally unacceptable) basis for commitment. The mentally retarded, who are limited in capacity to understand technical legal forms and procedures, are not assisted in any real way by the state's regulations. Young persons committed as mentally ill receive no effective protections under the state's present system.

16. "State action" is present in commitment of young persons to state-licensed facilities which are required to utilize and act in conformity with the challenged statutes and regulations. This is so on two alternative grounds:

a. The state has delegated to parents, guardians and institutions a power not possessed by the state, the power to deprive persons of liberty without minimal due process procedural protections. This is not a private commercial dispute and does not involve mere regulation of private business activities.

b. A detailed examination of the legal history of mental commitment in Pennsylvania demonstrates beyond peradventure that, beginning with the earliest colonial period of Pennsylvania history, through the Revolution and the State's first Constitution, and continuing through the 19th Century and into the 20th Century, mental commitment has been a sovereign power strictly under the control and perogative of the State. Although procedures shifted and varied, any commitment to any institution, whether "public" or "private," was a matter of exclusive and paramount state concern. Mental commitment has never been simply a private matter. Like education, elections, tax collection, fire and police protection, commitment of citizens to mental institutions in Pennsylvania has been a power traditionally exclusively reserved to the State.

17. On the propriety of the plaintiff subclasses, the defendants raise objections that were not raised at any point in the litigation below. Defendants should not be permitted to sit silent through a lawsuit, and give no hint of opposition to proposed subclasses, and then to claim error for the first time on appeal. In any event, on their merits, the objections must be rejected. After careful and reflective analysis, the lower court determined that plaintiff subclasses including all ages

of juveniles with common legal and factual connection with the state are proper. In addition, all persons subjected to institutionalization's dangers, whether for a month or for long term care are properly members of the same class where due process protections are held to apply to the very deprivation of liberty itself; the lower court balanced the length of commitment factor in determining what process is due. There was no abuse of discretion in certifying the plaintiff subclasses.

18. Nor is there any abuse of discretion in the certification of a class of defendant institutional directors where each is adequately represented by the Attorney General of Pennsylvania and where each of the 400 members of the class, as a practical matter and by operation of state law, would be bound by the result, and where none of the participating institutions objected to going forward.

19. The District Court's order that all young persons committed without hearings or counsel or other trained representative receive the benefit of the minimal process discussed above was proper and consistent with the mandate of *Preiser v. Rodriguez*, 411 U.S. 475 (1972), and *Wolff v. McDonnell*, 418 U.S. 539 (1973). The federal court did nothing to order or to speed any inmate's release. The court simply required the state to hold state proceedings where a state tribunal would make all individual determinations. This approach has been endorsed by this Court. *Gerstein v. Pugh*, 420 U.S. 103 (1975). *See Gomez v. Miller*, 341 F.Supp. 323 (S.D.N.Y. 1972), *aff'd sub nom. Miller v. Gomez*, 412 U.S. 914 (1973).

ARGUMENT

I.

PRIOR TO INVOLUNTARY INDETERMINATE MENTAL INSTITUTIONALIZATION UPON PARENTAL APPLICATION, YOUNG PERSONS ARE ENTITLED TO SUBSTANTIAL PROCEDURAL PROTECTIONS.

A. Institutionalization Results in Severe Deprivation of Liberty, Social Stigma, Self-Stigmatization and Discrimination.

Mental institutions are generally underfinanced, understaffed and overcrowded.[20] Commitment to such

[20]Hobbs, *The Futures of Children* 127-128 (1975). Provost Hobbs describes the familiar physical and fiscal realities in his report:

> Most public institutions are grossly and chronically underfinanced (Kugel, 1969). During 1966 and 1967 the per diem costs in United States institutions ranged from about $3 to $12 per person (U.S. Department of Health, Education and Welfare, 1968). In stark contrast, five of the largest United States zoos were spending, in a comparable period, an average of over $7 for their large animals (Kugel, 1969, p. 3). Further, in 1966, general hospital care cost more than $40 per day (Butterfield, 1969, p. 18).
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> * * *
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> Overcrowding is commonplace. Many residential facilities have as many as 25 to 50 percent more than they were intended to serve. Buildings that are old and poorly designed also create problems. For instance, lavoratory and toilet facilities are often poorly maintained and may even be nonfunctioning. Ancient facilities may make it difficult if not impossible to prepare food in a sanitary fashion; and climate control may be so inadequate as to leave buildings either too hot or too cold (Kugel, 1969, p. 405; Blatt and Kaplan, 1967). Equally inadequate are modern complexes of steel, chrome, and glass, when human caring is absent.

Id.

a residential facility necessarily entails a "massive curtailment of liberty," *Humphrey v. Cady*, 405 U.S. 504, 509 (1972), as persons are placed in a "total institution" in which every aspect of their lives is regulated by impersonal authority.[21] The dangers and negative effects of institutional treatment programs are well-known.[22] The process results in what one of the

[21]Goffman, *Asylums* (1961). As early as 1938, a federal appellate court recognized the similarities between the deprivations of liberty of people in mental institutions and those in prisons. *Barry v. Hall*, 98 F.2d 222 (D.C. Cir. 1938). A detailed comprison of the conditions in a psychiatric treatment center and a state prison—demonstrating the restrictiveness of the mental facility—is provided in "Brief of Donald McEwan, Pro Se" in Katz, Goldstein & Dershowitz, *Psychoanalysis, Psychiatry and the Law* 700-702 (1967). For discussion of the nature of mental treatment in the United States, *see* Note, *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 Harv. L. Rev. 1190, 1316-1376 (1974); Deutsch, *The Mentally Ill in America* (2d ed. 1949); Grob, *Mental Institutions in America: Social Policy to 1875* (1973); Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic* (1971); Kittrie, *The Right to Be Different: Deviance and Enforced Therapy* (1971); Rosen, *et al., The History of Mental Retardation: Collected Papers* (1976).

[22]Barton, *Institutional Neurosis* (2d ed. 1966); Belknap, *Human Problems of State Mental Hospitals* (1956); Gralnick, *et al.*, "Mental Patients in Transition" in Greenblatt, ed., *Mental Patients in Transition* (1961); Stanton and Schwartz, *The Mental Hospital* (1954); Wing and Brown, *Institutionalization and Schizophrenia* (1970); Vail, *Dehumanization and the Institutional Career* (1966); Klaber, *Retardates in Residence: A Study of Institutions* (Project RD-1816-P, Social and Rehabilitation Service, HEW, State of Connecticut, University of Hartford). *See* testimony of Dr. Ingall at 596a, Dr. Feiner at 474a-475a, Commissioner Glenn at 985a-990a.

defendants' own expert witnesses calls "an emotional deficiency disease" (715a). The "institution extracts, takes away liberties and opportunities in all areas once a person is placed there." Testimony of Commissioner Glenn at 986a.

Most juveniles entering the institutional mental health system have never received any psychiatric treatment before, stay longer than adults,[23] and a large proportion do not suffer from any major "illness."[24] Nevertheless, all are subjected to the process of institutionalization which can "make children sick," according to Nicholas Hobbs in his report volume for the HEW-sponsored Project on Classification of Exceptional Children:

[23]Most juveniles admitted to mental hospitals (53% in 1969) never before received psychiatric treatment; the figure for all age admissions is only 38.7%. Dept. of Health, Education and Welfare, NIMH, Statistical Note 90, *Utilization of Psychiatric Facilities by Persons Under 18 Years of Age, United States, 1971*, Table 9. Once in a private or public mental institution, juveniles stay longer than adults. *Id.* at Table 8.

[24]In 1975, the leading primary diagnosis of juveniles admitted to state and county mental institution was "transient situational disorders and behavior disorders of childhood" which accounted for 54.3% of all juvenile admissions. Dept. of Health, Education and Welfare, NIMH, Statistical Note 138, *Diagnostic Distribution of Admissions to Inpatient Services of State and County Mental Hospitals, United States, 1975*. Most of the nine Haverford plaintiffs here have been given such diagnoses. These relatively minor "transient situational disturbances" are those that "occur in individuals without any apparent underlying mental disorders and that represent an acute reaction to overwhelming environmental stress." American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* at 48 (2d ed. 1968).

Go to a big state mental hospital in almost any state and ask to visit the children's ward. If you are allowed to visit, you will find people, children and staff alike, caught up in a no-exit game. Patients and staff play their roles, each defined by the other, both prescribed by elaborate regulations and procedures that serve one purpose: to maintain the stability of the institution. Most of these institutions are so large, so unwieldly, so antiquated in design, so poorly staffed, so burdened with the miseries of man that everyone involved must devote most of his energies to maintaining a steady-state situation. The metaphor of illness rules. Change in or deviation from role requirements cannot be tolerated. Apathy goes unnoticed. Precise adherence to role expectation is praised and rewarded, while deviations and serious efforts to change the system are punished. In such a setting, hospitals can indeed make children sick.[25]

The particular dangers of institutionalization for the retarded include a high rate of mortality (generally higher, especially for the young, than in the community); an adverse effect on intelligence and an abnormally high prevalence of personality disorders.[26]

[25]Hobbs, *supra* note 20, at 130. Institutional care during early childhood is especially to be avoided. There is strong evidence that one institutional admission of longer than a week or repeated admissions before the age of 5 are associated with increased behavior disturbances and instability in adolescence. Douglas, *Early Hospital Admissions and Later Disturbances of Behavior and Learning*, 17 Dev. Med. Child Neurol. 456 (1975); Quinton, *Early Hospital Admissions and Later Disturbances of Behavior: An Attempted Replication of Douglas' Findings*, 18 Dev. Med. Child Neurol. 447 (1976).

[26]Studies collected in Edgerton, *et al.*, "Mental Retardation System," in Hobbs, ed., *Issues in the Classification of Children, Vol. II*, 63-64 (1975).

Harmful stereotypical "institutional" behaviors (such as biting and head banging) are learned by the retarded who live in institutions.[27]

After the emergence of the first institutions for the retarded in the United States 120 years ago in an atmosphere of optimism, the facilities failed to fulfill their expectations for cure or rehabilitation. By 1880, the earlier prevention model was succeeded by a "pity model" which supported the provision of custodial care. By the turn of the century and with the development of the eugenics movement,[28] a societal image of the retarded as a danger and a menace to society became fixed.[29] As one commentator explains the effect today of this history:

> . . . many of our institutions, to this very day, operate in the spirit of 1925 when inexpensive segregation of the scarcely human retardate was seen as the only feasible alternative to combat a social menace. I am not proposing that this view is still held; I am proposing that most institutions function as *if this* view were still held.[30]

[27]Testimony of Commissioner Glenn at 987a-988a.

[28]*See Buck v. Bell*, 274 U.S. 200 (1927), upholding a statute growing out of this movement.

[29]For analysis of this development, *see* Baumeister, *The American Residential Institution: Its History and Character* in Baumeister and Butterfield, eds., *Residential Facilities for the Mentally Retarded* (1970); Kugel and Wolfensberger, eds., *Changing Patterns in Residential Services for the Mentally Retarded* (1969); *Halderman v. Pennhurst State School and Hospital*, 446 F.Supp. 1295 (E.D.Pa. 1977).

[30]Wolfensberger, *The Origin and Nature of Our Institutional Models*, in Kugel and Wolfensberger, *supra* note 29, at 129 (emphasis in original).

Institutions for the retarded are known to subject their inmates to regimented, impersonal and warehouse-like conditions.[31] For example, this is the way one federal court describes the daily routine in the institution to which plaintiff George S. has been committed for the past eight years:

> These institutions are the most isolated and restrictive settings in which to treat the retarded. Pennhurst is almost totally impersonal. Its residents have no privacy—they sleep in large, overcrowded wards, spend their waking hours together in large day rooms and eat in a large group setting. They must conform to the schedule of the institution which allows for no individual flexibility. Thus, for example, all residents on Unit 7 go to bed between 8:00 and 8:30 p.m., are awakened and taken to the toilet at 12:00-12:30 a.m. and return to sleep until 5:30 a.m. when they are awakened for the day, which begins with being toileted and then having to wait for a 7:00 a.m. breakfast.[32]

[31] *See Halderman v. Pennhurst State School and Hospital*, 446 F.Supp. 1295 (E.D. Pa. 1975). When institutionalized retarded children experience adult contact, it is almost exclusively for management, custodial or child-care purposes; only 4% of ward attendants' time is devoted to training and habilitation. Velt, *Interpersonal Interactions Between Institutionalized Retarded Children and Their Attendants*, 80 Am.J. Mental Defic. 535 (1976). One study notes that the practice of moving institutionalized juveniles and staff from one unit to another can be devastating; during a 3½ year period, at least 99 different day staff were on duty with the children being cared for by a total of 246 different adults. The children were moved at least twice and some as many as 18 times. Tizard, *The Role of Social Institutions in the Causation, Prevention and Alleviation of Mental Retardation*, Haywood, *Social-Cultural Aspects of Mental Retardation* (1970). *See* Klaber, *supra* note 22.

The "deprivation of liberty inherent in institutionalization" for young persons classified as mentally ill and mentally retarded is accurately summarized by the District Court:

> One expert testified to the "derailment from the usual course of one's life, the dreary regimen even in the most progressive hospitals, the extreme deprivation and limits" which are the effects of institutionalization. Institutions prevent persons from being exposed to normal community experiences and prevent individual growth. With respect to mentally retarded persons, these conditions may be rendered even more acute by the person's inability to protect himself against the dehumanizing effects of institutionalization. Finally, these effects appear to be the same regardless of whether the institution is state-operated or privately-operated; the crucial variable is size.[33]

The "powerful long-term effect on the individual's life" (990a) of institutionalization reverberates long after release from the facility.

[32] *Halderman v. Pennhurst State School and Hospital, supra* note 31, 446 F.Supp. at 1303 (citations omitted). Many other courts have found similar regimented and depersonalized conditions in institutions for the retarded across the country. *E.g., New York State Association for Retarded Children v. Rockefeller*, 357 F.Supp. 752 (E.D.N.Y. 1973), *modified*, No. 72-C-356/357 (E.D.N.Y., May 23, 1973), 393 F.Supp. 715 (E.D.N.Y. 1975) (approving consent order); *Horacek v. Exon*, 354 F.Supp. 71 (D. Neb. 1973); *Wyatt v. Stickney*, 325 F.Supp. 781 (M.D.Ala. 1971), 334 F.Supp. 1341 (M.D. Ala. 1971), 344 F.Supp. 373 and 387 (M.D. Ala. 1972), *aff'd sub nom. Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974).

[33] Opinion at 1070a.

Severe social stigma, self-stigmatization, job and license discrimination also result from the experience of commitment to mental institutions for the mentally ill and the retarded.[34] It is the fact of institutionalization, not the procedures used, which stigmatizes.[35] As

[34]Opinions at 795a, 1067a, 1077a-1078a. On stigma generally, *see Goffman, Stigma: Notes on the Management of Spoiled Identity* (1963). Regarding stigma and the mentally ill, *see, e.g.*, Testimony of Dr. Kandler at 574a-575a, Dr. Messinger at 622a, Dr. Feiner at 475a, Dr. Ingall at 596a and Dr. Miller at 705a; *In re Ballay*, 482 F.2d 648, 668 (D.C. Cir. 1973); *Lessard v. Schmidt*, 349 F.Supp. 1078 (E.D. Wis. 1972), *vacated and remanded*, 414 U.S. 473 (1974), *on remand*, 379 F.Supp. 1376 (E.D.Wis. 1974), *vacated and remanded*, 421 U.S. 957 (1975), *on remand*, 413 F.Supp. 1318 (E.D.Wis. 1976); Braginsky, *et al., Methods of Madness: The Mental Hospital as a Last Resort* (1969). On the mentally retarded and stigma, *see Pennsylvania Association for Retarded Children v. Commonwealth of Pennsylvania*, 343 F.Supp. 279, 293-295 (E.D.Pa. 1972); Edgerton, *The Cloak of Competence: Stigma in the Lives of the Mentally Retarded* (1967); Braginsky & Braginsky, *Hansels and Gretels: Studies of Children in Institutions for the "Mentally Retarded"* (1971); Severance & Gasstrom, *Effects of the Label "Mentally Retarded" on Causal Explanations for Success and Failure Outcomes*, 81 Am. J. of Mental Def. 547 (1977). In one study of school children in the community, school teachers were found to have low expectancies of students labeled retarded; the teachers maintained these expectancies even when confronted with normal behavior and, in fact, misinterpreted actual behavior in response to their bias. Foster *et al., Expectancy and Halo Effects as a Result of Artificially Induced Teachers Bias*, 1 Contemporary Educational Psychology 37 (1976).

[35]"Unfortunately, there is a stigma being attached to being in a hospital, which would be another reason why all care ought to be taken before this type of drastic step be taken. I never heard the fact that a judge or attorney being involved in a proceeding increases that stigma." Testimony of Dr. Kandler at 574a-575a.

(continued)

the lower court found, this "stigma is imposed both outwardly, in that juveniles who have been in institutions encounter substantial obstacles in the community, and inwardly in that the self-image of the juvenile is almost severely damaged."[36]

(footnote continued from preceding page)

Non-institutional mental health care is not viewed in the same highly negative way as is institutional care:

> The lay public seems to adhere to a single operational definition of the mental patient. To the average man, a person becomes a mental patient only when he enters a psychiatric hospital.

Rabkin, *Public Attitudes Toward Mental Illness: A Review of the Literature*, 10 Schizophrenia Bull. 9 (1964). This deprecating label, which applies for an indefinite period after discharge from the institution, is not in general used for psychiatric patients seen only in private consultation or clinics. *Id.*

[36]Opinion at 1067a (notes omitted). The public fears, distrusts, dislikes and excludes those persons labeled "mental patients." Rabkin, *supra* note 35. The prejudice against mental illness results not simply from an ignorant or biased public but, in part, from the activities of psychiatrists. Schwartz & Schwartz, *Reducing the Stigma of Mental Illness*, 38 Diseases of the Nervous System 101 (1977). Numerous studies document the self-stigmatization which lowers self-esteem and encourages aberrant behavior in both mentally ill and mentally retarded institutionalized persons. *E.g.*, Lindsey, *Patient Inquiry Into Mental Hospitalization: A Quantitative Analysis*, 10 Adolescence 337 (1975); Bouliew, *Do Institutions Maintain Retarded Behavior*, 9 Mental Retardation 36 (1971). Commissioner Glenn testified that, with regard to those persons committed as retarded, "the stigma really hurts the person's later integration into the community. * * * The discrimination that is placed on these people is quite traumatic." (991a). *See also* authorities cited *supra* at note 34.

B. Liberty Interests Under the Fourteenth Amendment Are Implicated by the Commitment of Young Persons to Mental Institutions.

Mental commitment is generally considered a deprivation of liberty under the Fourteenth Amendment and the states are required to provide substantial procedures to protect persons from erroneous commitment to mental institutions:

> There can be no doubt that involuntary commitment to a mental hospital, like involuntary confinement of an individual for any reason, is a deprivation of liberty which the state cannot accomplish without due process of law. Specht v. Patterson, 386 U.S., at 608, 18 L.Ed.2d 527, 87 S.Ct. 1428 (1967). Commitment must be justified on the basis of a legitimate state interest, and the reasons for committing a particular individual must be established in an appropriate proceeding.

O'Connor v. Donaldson, 422 U.S. 563, 580 (1975) (Chief Justice Burger, concurring). This Court has consistently upheld claims by inmates of mental institutions to hearing and other procedures protective of their constitutional rights. *Baxstrom v. Herold*, 383 U.S. 197 (1966); *Specht v. Patterson*, 386 U.S. 605 (1967); *Jackson v. Indiana*, 406 U.S. 715 (1972); *Humphrey v. Cady*, 405 U.S. 504 (1972); *McNeil v. Director, Patuxent Institution*, 407 U.S. 245 (1972).[37]

[37]The lower federal courts have uniformly held that due process mandates procedures similar or identical to those required by the District Court here. *E.g., Lessard v. Schmidt, supra* note 34; *Lynch v. Baxley*, 386 F.Supp. 378 (M.D.Ala. 1974); *Bell v. Wayne County*, 386 F.Supp. 1085 (E.D. Mich. *(continued)*

The Court's deep concern that due process be afforded to the mentally disabled is by no means newly conceived. Sixty years ago, in *Chaloner v. Sherman*, 242 U.S. 455 (1917), a challenge was made to state mental incompetency procedures. Speaking for a unanimous court, Justice Brandeis declared:

> As the plaintiff had notice and opportunity to be heard at each stage of the proceedings, the essential elements of due process of law were fully met, and the court had jurisdiction to enter that order.

242 U.S. at 455. *See also Dexter v. Hall*, 82 U.S. 9, 25 (1872) (". . . a lunatic needs more protection than a minor." "Both such classes of persons are regarded as under the protection of the law.").

In an attack on Minnesota mental commitment procedures, this Court upheld a statute which provided for a hearing, counsel, confrontation, a record and the right to appeal. *Minnesota ex rel. Pearson v. Probate Court of Ramsey County*, 309 U.S. 270, 276-277 (1940) ("We fully recognize the danger of a deprivation of due process in proceedings dealing with persons charged

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1974); *Dixon v. Attorney General of the Commonwealth of Pennsylvania*, 325 F.Supp. 966 (M.D. Pa. 1971); *Heryford v. Parker*, 396 F.2d 393 (10th Cir. 1968); *In re Ballay, supra* note 34; *In re Basso*, 299 F.2d 933 (D.C. Cir. 1962); *In re Barnard*, 455 F.2d 1370 (D.C. Cir. 1971); *Sarzen v. Gaughan*, 489 F.2d 1076 (1st Cir. 1973); *Kendall v. True*, 391 F.Supp. 413 (W.D. Ky. 1975); *Barry v. Hall, supra* note 21; *Doremus v. Farrell*, 407 F.Supp. 509 (D. Neb. 1976); *Suzuki v. Quisenberry*, 411 F.Supp. 1113 (D. Hawaii 1976); *Suzuki v. Alba*, 438 F.Supp. 1106 (D. Hawaii 1977).

with insanity or, as here, with a psychopathic personality as defined in the statute.").[38]

In *Specht v. Patterson*, 386 U.S. 605 (1967), the Court rejected the notion that individual rights can be bypassed by labeling a procedure "civil" rather than "criminal."[39] Discussing mental commitment proceedings under the Colorado Sex Offender Act, the Court held, "These commitment proceedings whether denominated civil or criminal are subject both to the Equal Protection Clause of the Fourteenth Amendment as we held in *Baxstrom v. Herold*, 383 U.S. 107, 86 S.Ct. 750, 15 L.Ed.2d 620, and to the Due Process Clause." *Specht*, 386 U.S. at 608.[40]

[38] *See Logan v. Arafeh*, 356 F.Supp. 1265 (D. Conn. 1972), *aff'd mem. sub nom. Briggs v. Arafeh*, 411 U.S. 911 (1973), where the district court upheld a statute noting that a "judicial decision after receiving evidence from a general physician and a psychiatrist in an adversary hearing is fully adequate to safeguard against involuntary commitment through mistake or abuse." 346 F.Supp. at 1270. *Logan* permitted a delay in hearings for people certified as "dangerous;" the Pennsylvania statutes here require only a finding of "in need of care or observation," 1966 Act, or "in need of treatment." 1976 Act.

[39] The irrelevance of civil-criminal labels was the basis for the decision in *Giacco v. Pennsylvania*, 382 U.S. 399 (1966), where an acquitted criminal defendant challenged a state law permitting a jury to assess costs against him. Pennsylvania courts characterized the statute as "of a civil character." Noting that it "provides the State with a procedure for depriving an acquitted defendant of his liberty and his property," the Court held that Fourteenth Amendment "protection is not to be avoided by the simple label a State chooses to fasten upon its conduct or statute." 382 U.S. at 402.

[40] The due process required in mental commitments today is not unlike that described by Blackstone. Before a person could be

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The pervasive concern has been that no person may be caused to suffer a loss of liberty—for whatever reason—without stringent decision-making requirements designed to minimize the ever-present risk of error and to assure proper disposition of the case.[41]

The defendants, invoking the "family's right of privacy" and "the sanctity of parental responsibility,"[42] maintain that a young person's constitutional right to

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declared retarded ("an idiot"), a writ *de idiota inquirendo* would be filed and "tried by a jury of twelve men;" a declaration that one was mentally ill (a "lunatic") did not occur until after the lord chancellor, "upon petition or information, grants a commission in the nature of the writ *de idiota inquirendo*, to inquire into the party's state of mind." Blackstone, *Commentaries on the Laws of England* 305 (Wendell, ed., 1852). In Blackstone's day, "The legislature, to prevent all abuses incident to such private custody, hath thought proper to interpose its authority, by statute [citation omitted] for regulating private mad-houses." *Id.* As discussed more fully below, *infra* at §II.B., from its earliest Constitution and laws until recently, Pennsylvania required judicial proceedings for mental commitments of all persons, regardless of age, to mental institutions, whether publicly owned or not.

[41] Discussing mental commitments, Wigmore declares, "In such proceedings, *nothing can excuse the judge from personally hearing and examining the party* to be committed" (emphasis in original) because of the extreme risk of an improper commitment:

> No greater cruelty can be committed in the name of the law. And any statute which makes such a result possible, by refusing to let a sane person appear before the judge and plead his own case and hear the witnesses against him, is a thoroughly bad statute.

5 Wigmore, *Evidence* §1400 (3d ed., 1940) (footnote omitted).

[42] Brief for Appellants at 28.

liberty is not implicated at all in mental institutionalization. Finding no support in any previous decision of this Court, this conclusion misconceives constitutional doctrine which full recognizes the applicability of the central meaning of liberty—freedom from physical confinement—to young persons, while setting variable limits on other asserted liberties of minors under the Fourteenth Amendment.

The "power of the state to control the conduct of children reaches beyond the scope of its authority over adults." *Prince v. Massachusetts*, 321 U.S. 158, 170 (1944). For example, young persons may be required to receive a basic education in school, *Wisconsin v. Yoder*, 406 U.S. 205, 213 (1972), and may be limited in their access to objectionable material. *Ginsberg v. New York*, 390 U.S. 629 (1968). In addition, parents and guardians have the right to direct the upbringing of their children in their early and formative years. *E.g., Pierce v. Society of Sisters*, 268 U.S. 510 (1925).

Two controlling principles emerge from the Court's decisions regarding parents and children. Where the state unreasonably intrudes into the family's domain and thereby jeopardizes the family's function and strength as the primary socialization mechanism, the state's intrusion will be struck down. *See Meyer v. Nebraska*, 262 U.S. 390 (1923); *Pierce v. Society of Sisters*, 268 U.S. 510 (1925); *Wisconsin v. Yoder*, 406 U.S. 205 (1971). In precisely parallel fashion, where parental decisions unreasonably jeopardize the young person's "opportunities for growth into free and independent well-developed men and citizens," governmental intrusions into the family will be upheld. *Prince v. Massachusetts*, 321 U.S. 158, 165 (1944). In *Prince*,

the Court upheld restrictions on the rights of guardians and supported certain regulation of family interests, explaining:

> But the family itself is not beyond regulation in the public interest, as against a claim of religious liberty. [citations omitted] And neither rights of religion nor rights of parenthood are beyond limitation. Acting to guard the general interest in youth's well-being, the state as *parens patriae* may restrict the parent's control by requiring school attendance, regulating or prohibiting the child's labor and in many other ways.

Id. at 166 (notes omitted). And more recently, in *Wisconsin v. Yoder*, 406 U.S. 205 (1972), limitations on parental powers continued to receive approval; such regulation is proper "if it appears that parental decisions will jeopardize the health or safety of the child, or have a potential for significant social burdens." *Id.* at 234.

The extent of control over juveniles by parents and guardians is broad enough to provide appropriate deference to the "importance of the family," *Stanley v. Illinois*, 405 U.S. 645, 651 (1972), but narrow enough to protect the independent personal interests of the most powerless of the family's members.[43] The presence of "family interests" in a case does not efface the interests of the child as an individual.

Other courts have uniformly agreed that, in the parent-child context, the law as *parens patriae* must

[43]Dr. Feiner testified that ". . . the child has some intrinsic vulnerability based upon the fact the child is dependent to begin with, the child is more controllable in certain ways, the child is also often a newcomer to the setting, the last to be present in this little system . . ." (472a).

protect the welfare of children, an interest to which that of parents must yield.[44] The key consideration in all these cases is that society has an interest—independent of parents—in assuring the welfare of children.

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[44]The issue arises most often in custody cases. *E.g., Holtsclaw v. Mercer*, 145 F.2d 388 (D.C. Cir. 1944); *Langan v. Langan*, 150 F.2d 979 (D.C. Cir. 1945). *See In re Stuart*, 114 F.2d 825 (D.C. Cir. 1940) (right of parents to control upbringing of children not absolute); *Newton v. Burgin*, 363 F.Supp. 782 (W.D.N.Ca. 1973) (Three-Judge Court), *aff'd*, 414 U.S. 1139 (1974) (parental constitutional right to control children can be limited by statute).

Among the many situations in which parental "rights" and "powers" have been held properly restricted are juveniles curfews, *Bykofsky v. Borough of Middletown*, 401 F.Supp. 1242 (M.D. Pa. 1975), *cert. den.*, __ U.S. __ ; drinking age laws, *Republican College Council of Pennsylvania v. Winner*, 357 F.Supp. 739 (E.D.Pa. 1973); sex education, *Cornwell v. State Board of Education*, 314 F.Supp. 340 (D. Md. 1969), *aff'd*, 428 F.2d 471 (8th Cir. 1970), *cert. den.*, 400 U.S. 942 (1970); blood transfusions, *People ex rel. Wallace v. Labrenz*, 411 Ill. 618, 104 N.E.2d 769 (1952), *cert. den.*, 344 U.S. 824 (1952); corporal punishment, *Ware v. Estes*, 328 F.Supp. 657 (N.D.Tex. 1971); visitation, *Comm. ex rel. Heston v. Heston*, 98 A.2d 477, 173 Pa.Super. 260 (1953); approval of personal injury settlements, *Rafferty v. Rainey*, 292 F.Supp. 152 (E.D. Tenn. 1968); abortion, *In re Smith*, 295 A.2d 238, 16 Md.App. 209 (1972) (mother cannot compel daughter to submit to abortion); organ transplants, *Hart v. Brown*, 289 A.2d 385, 29 Conn.Sup. 368 (1972); sterilization, *Frazier v. Levi*, 440 S.W.2d 393, 394 (Civil App. Tex. 1969); and monetary matters. *Ellis v. Massenberg*, 126 N.C. 129, 35 S.E. 40 (1900) (action to set aside deed); *White v. Osborne*, 251 N.C. 56, 110 S.E.2d 449 (1959); *Babcock v. Fisk*, 327 Mich. 72 (1950) (control of publicly raised funds).

The contrary assertion of defendants that, except in life-or-death situations, parental wishes always prevail over asserted interests of children, is totally unsupported in law or reason and must be rejected.

Where constitutional rights are at stake, and family interests are not implicated, this Court has recognized claims by young persons asserting liberties in various substantive and procedural realms. *E.g., Goss v. Lopez*, 419 U.S. 565 (1975) (suspension from public school); *Tinker v. Des Moines Independent Community School District*, 393 U.S. 503, 506-507 (1969) (First Amendment right to political expression);[45] *Erznoznik v. City of Jacksonville*, 422 U.S. 205, 212-214 (1975) (First Amendment interest in flow of communicative material); *Ingraham v. Wright*, 430 U.S. 651, 672-674 (1977) (Due Process right to be free from unjustified intrusions on personal security); *Carey v. Population Services International*, 431 U.S. 678 (1977) (access to contraceptives). In these cases, while the *extent* of minors' liberty interests was held subject to possible limitation, the *existence and nature* of those liberty interests, similar to those of adults, was nevertheless recognized.

One liberty interest of young persons which has repeatedly been identified by this Court as implicated by the Fourteenth Amendment is the right to be free from physical confinement. *See Haley v. Ohio*, 332 U.S. 596, 601 (1948); *Gallegos v. Colorado*, 370 U.S. 49, 54 (1952); *Kent v. United States*, 383 U.S. 541 (1966); *In re Gault*, 387 U.S. 1 (1967); *In re Winship*, 397 U.S. 358 (1970); *McKeiver v. Pennsylvania*, 403 U.S. 528 (1971); *Breed v. Jones*, 421 U.S. 519 (1975). These cases do not admit of any question as to the extent of the juvenile's liberty interest in not being confined, for whatever purpose, in an institution.

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[45]The students' ages in *Tinker* were 8, 11, 13, 15 and 16. 393 U.S. at 516.

There is no suggestion in these decisions that parental endorsement of a decision to separate the young person from the home and to confine him or her in an institution somehow nullifies the minor's Fourteenth Amendment interests.[46]

The *Haley-Gault-Breed* line of cases are emphatic that a constitutional liberty is discerned even if the purpose of the confinement is "clinical"[47] treatment or "to save the child:"[48]

> Regardless of the purposes for which the incarceration is imposed, the fact remains that it is incarceration. The rehabilitative goals of the system are admirable, but they do not change the drastic nature of the action taken.

Breed v. Jones, supra, 421 U.S. at 530, n. 12.[49]

[46]In *Ginsberg v. New York*, 390 U.S. 629 (1968), the Court held that the Constitution supports the parental "claim to authority *in their own household*" to direct the rearing of children. *Id.* at 639 (emphasis added). This suggests that parental authority may not be absolute when the young person is excluded from the household.

[47]*In re Gault*, 387 U.S. 1, 16 (1967).

[48]*In re Winship*, 397 U.S. 358, 365-366 (1970).

[49]A case strikingly on point is *Heryford v. Parker*, 396 F.2d 393 (10th Cir. 1968), where a nine year old child was committed to a training school for the feeble-minded and epileptic:

> But, like *Gault*, and of utmost importance, we have a situation in which the liberty of an individual is at stake, and we think the reasoning in *Gault* emphatically applies. It matters not whether the proceedings be labelled "civil" or "criminal" or whether the subject matter be mental instability or juvenile delinquency. It is the likelihood of involuntary incarceration—whether for punishment as an adult for a crime, rehabilitation as a juvenile for delinquency, or treatment and training for a feeble-minded

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It would have made no constitutional difference if Gerald Gault's mother had favored his confinement for making an obscene telephone call or if Gary Steven Jones' mother had preferred that he be tried as an adult for robbery.

The deprivation of liberty and other harms which flow from commitment are accompanied by the serious and irreparable stigma described above. Such injury to standing, reputation and one's future functioning as a citizen, coupled with the deprivation of physical freedom, implicates the young persons' liberty interests under the Fourteenth Amendment. *See Wisconsin v. Constantineau*, 400 U.S. 433 (1971); *Paul v. Davis*, 424 U.S. 693 (1976).[50]

Without question, the Fourteenth Amendment liberty interests of young persons are affected when

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> or mental incompetent—which commands of the constitutional safeguards of due process.

396 F.2d at 396. *See Saville v. Treadway*, 404 F.Supp. 430 (M.D.Tenn. 1974); *Kidd v. Schmidt*, 399 F.Supp. 301 (E.D. Wis. 1975).

[50]*See* Note, *Developments in the Law, supra* note 21, 87 Harv. L. Rev. at 1198-1201. In *Gary W. v. Louisiana*, the court concluded:

> Involuntary institutional confinement of any person, adult or child, entails a "massive curtailment of liberty," Humphrey v. Cady, 1972, 405 U.S. 504, 509. Such institutionalization stigmatizes those confined and may at times exceed even criminal incarceration in its destructive impact on an individual's personal freedom.

437 F.Supp. 1209, 1216 (E.D. La. 1976) (commitment of children to mental institutions).

they are indeterminately confined in mental institutions.[51]

C. The Constitutional Rights of Young Persons in the Mental Institutionalization Process are not Overcome by Parental Application for Commitment.

The Facts Regarding Families Seeking Commitment of "Mentally Ill" Minors

As the lower court's unchallenged factual findings[52] and the record in this litigation shout forth, applications for commitment of young persons to mental institutions are not the expression of calm, rational, reliable, informed conflict-free parents and guardians. On the contrary, the expert witnesses for all parties

[51]This conclusion is reached in a persuasive recent analysis of the question. Teitelbaum & Ellis, *The Liberty Interest of Children: Due Process Rights and Their Application*, 12 Family Law Quarterly 153 (Fall, 1978).

Defendants raise the spectre of application of the decision in this case to provision of services in the community in non-institutional home-like settings. Brief for Appellants at 34, n. 17. The complaint, the lower court's opinions, findings and order, however, deal only with institution-based residential care as distinguished from community-based care. Plaintiffs make no claim regarding non-institutional care in this case.

[52]Opinion at 1060a-1070a. The defendants do not challenge any factual findings on appeal as clearly erroneous. *See* Fed. R. Civ. Pro. 52(a); *United States v. United States Gypsum Co.*, 333 U.S. 364, 394-395 (1948) (stating rule); *Graver Tank & Mfg. Co. v. Linde Air Products Co.*, 336 U.S. 271, 274-275 (1949) (application of "clearly erroneous" test to findings based largely on expert testimony).

agreed that families seeking commitment of allegedly handicapped children are characterized by severe stress, disharmony and dislocation.[53] The problems of children are a function of intrafamilial problems and exist in a context of a weakened family structure with conflict overtly expressed.[54] The juvenile behavior which precipitates institutionalization may be provoked by the parents; there are also many cases where the child may be driven to such behavior by the conflicts at home.[55]

[53]*See* testimony of Dr. Kandler at 543a, 553a-554a, 570a-571a; Dr. Ingall at 588a-590a, 601a; Dr. Messinger at 616a-619a; Dr. Tashjian at 651a-652a, 656a-657a; Dr. Masterson at 727a-728a, 733a-734a. *E.g.*, Alanen, *The Family in the Pathogenesis of Schizophrenia and Neurotic Disorders*, 24 Acta Psychiatrica et Neurologica Scandinavica, Suppl. 189 (1966); Lidz, *et al., Schizophrenia and the Family* (1966); Lidz, *et al., The Intrafamilial Environment of Schizophrenic Patients. II. Marital Schism and Marital Skew*, 114 Amer. J. of Psychiatry 281 (1957). *See generally*, Fleck, *Some Basic Aspects of Family Pathology*, in Wolman, ed., *Manual of Child Psychopathology* 189 (1972).

[54]*See* testimony of Dr. Ingall at 588a, 610a; Dr. Messinger at 616a-619a; Dr. Masterson at 733a-734a; Dr. Tashjian at 668a-669a; Dr. Feiner at 467a-469a, 471a-472a, 501a-502a; Wohlman, *Family Dynamics and Schizophrenia*, 6 J. of Health and Human Behavior 147 (1965); Weeks & Mack, *The Child*, in Nicholi, ed., *The Harvard Guide to Modern Psychiatry* (1978).

[55]*See* testimony of Dr. Masterson at 733a; Dr. Feiner at 468a. One court which noted the possibility that a "breakdown in parental control" of a child could result from failings in the parent rather than in the minor, required inquiry into "intra-family parent-child conflict." *In re Henry G.*, 28 C.A.2d 276, 284-285, 104 C.R. 585 (1972), describes the issue in this way:

> The Fourth Commandment is still an integral part of the beliefs of our society. It is one thing, however, to say that a teen-age minor has struck the parent—it is another thing if that striking is done in self-defense and in response to traumatic situations initiated by the parent.

Parents will often seek to institutionalize children for improper reasons. This stems from honest mistakes, ignorance, lack of awareness of alternatives to institutionalization, lack of community resources or sometimes from malice or ill will.[56] In a significant number of cases, the parental purpose of bringing a child to treatment "has been to accuse him, to punish him, to separate him from the home. The motivation is not always good."[57]

Experts for both plaintiffs and defendants were in agreement that parents are not particularly good observers of children's behavior and symptoms and, especially with the high feelings that run in these situations, parents are not reliable sources of factual information about the child and his or her behavior.[58] Parents who bring their child to professionals seeking care "can't be objective reporters" of the behavioral background of the child.[59] Parents often exaggerate and misinterpret the actions of their children and may often react antagonistically to their children, in these cases.[60]

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[56] *See* testimony of Dr. Kandler at 543a, 553a-554a; Dr. Miller at 685a.

[57] Testimony of Dr. Ingall at 601a.

[58] *See* testimony of Dr. Masterson at 733a; Dr. Kandler at 543a; Dr. Ingall at 592a, 601a; Dr. Sugar at 401a.

[59] Testimony of Dr. Feiner at 478a. *See* testimony of Dr. Messinger at 623a-624a.

[60] Testimony of Dr. Sugar at 404a-408a. Young persons are often committed not to resolve problems but to avoid them:

> From the point of view of the family, the primary function of scapegoating is that it permits the family to maintain its solidarity. In all the disturbed families, there were very

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The roster of Haverford State Hospital plaintiffs committed under the challenged statute is a complete one as of the time suit was filed; no selection, random or otherwise, was made (945a). Every one of these young persons comes from a disrupted, chaotic or conflicted home. For example, Kevin S. was physically abused by his schizophrenic mother who had lied to obtain her own admission to a mental hospital to give birth to him. Richard S.' mother did not have him home until he was two and he stayed with her only two years. James Paul M. lived with just his father, his mother having died not long before his commitment. Edward B.'s parents admitted tricking him into the hospital. Richard C.'s father had a drinking problem.

William B's parents separated during his infancy; he was committed after he began living with his father, stepmother and stepbrothers. According to hospital records, his life with family members subjected him to extreme inconsistency, disorganization and lack of structure. Similarly, Francis B. comes from a disorganized family which rejected him (the records refer to "the almost total rejection of Frankie by everyone in his

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> severe strains which continuously threatened to disrupt the family. . . . By focusing on one particular child, the families were able to encapsulate problems and anxieties which could potentially disrupt various family processes. There seemed to be an added solidarity between the parents who stood united against the problem child. The fact that it is a child who is disturbed permits the parents to continue to perform the tasks necessary for household maintenance.

Vogel & Bell, *The Emotionally Disturbed Child as the Family Scapegoat*, in *A Modern Introduction to the Family* 125 (1968). *See also*, Laing & Esterson, *Sanity, Madness and the Family* (1964).

family"). There is a question of physical abuse in his case; this plaintiff "could no[t] do right in parents' eyes."

Maria L.'s parents were saved from divorce only by the birth of a new child. Her father drinks and won't assume any responsibility for the four children in the family. Her mother, on the brink of mental breaddown, several times tried to choke Maria.Thomas W.'s mother and stepfather, involved in an unstable marriage, were arrested after a severe beating of Thomas which resulted in his hospitalization. Social service agencies have cared for him since.

When these family dynamics are viewed in the context of the alleged behaviors which precipitate the request for commitment, "conflicts between the concerns and interests of the parents, and the best interests of the child frequently arise. . . ."[61]

The Facts Regarding Families Seeking Commitment of "Retarded" Minors

Stereotypes regarding the retarded and their mental institutionalization are tragically hardened and erroneous. A person's level of retardation does not predetermine his or her need for institutionalization.[62]

[61]Opinion at 1068a. *See* authorities cited *supra* at notes 53, 54 and 60. In a recent study of 587 inpatient psychiatric admissions of children over a five year period, it was found that low functioning psychotic children are admitted to psychiatric hospitals not because of a change in the child's behavior but because of the particular stress on the family. Hagamen, *Family Support Systems: Their Effect on Long-Term Psychiatric Hospitalization in Children*, 16 J. Amer. Acad. Child Psychiatry 53 (1977).

[62]Testimony of Commissioner Glenn at 997a.

While degree of intellectual and physical impairment is a factor in determining institutionalization of retarded individuals, it clearly does not stand alone nor is it necessarily the most important. Other factors are the degree of family disorganization, demographic characteristics, parental attitudes toward childrearing and mental retardation, availability of community resources, and the professional philosophies of those consulted for advice.[63] "Professional philosophies influence decisions because patient oriented clinicians are more likely to give first priority to factors they consider advantageous to the child, whereas family oriented clinicians are more likely to base their recommendations on those which they assume to be best for the family."[64]

Parents of retarded persons often resort to seeking institutionalization as a means of securing relief from severe physical and emotional strains and because of a lack of finances and adequate community resources:[65]

> However, if these parents are "given honest information about residential and community alternatives and time to reflect," most of them

[63]*E.g.*, Eyman, *et al., Factors Determining Residential Placement of Mentally Retarded Children*, 76 Amer. J. of Mental Deficiency 693 (1966); Gralicker, *et al., A Study of Factors Influencing Placement of Retarded Children in a State Residential Institution*, 69 Amer. J. of Mental Deficiency 553 (1965).

[64]Eyman, *op. cit. supra* note 63, at 697.

[65]*See, e.g.*, Justice, *et al., Problems Reported by Parents of Mentally Retarded Children—Who Helps?*, 75 Amer. J. of Mental Deficiency 685 (1971). For a sensitive discussion of what parents face, see testimony of Glenn at 1001a-1005a. *See also* Teitelbaum and Ellis, *supra* note 51.

> "come to realize that the placement in most institutions means placing a lid on the child's potential by consigning him to custodial care—sometimes humane but often inhumane by anyone's standards. Most good residential schools (offering education and training as well as care) are extremely expensive. Most state institutions are still little more than warehouses which 'store' people."[66]

Inappropriate and unneeded institutionalization is often the unintended result.

The three named plaintiffs committed as retarded include two who are only moderately retarded. George S., abandoned by his parents, was institutionalized after a foster mother became ill and a second foster home became too crowded. Gina S., was placed out of the family home when her parents divorced and, three years later, was taken by her mother directly from the county infants' home to the mental institution. Both parents of Nancy Louise D. were alcoholic and mentally retarded; the county welfare department placed her first in foster care and then into the institution.

The only evidence on these matters is the expert testimony of Linda Glenn, Assistant Commissioner for Mental Retardation, Department of Mental Health, Commonwealth of Massachusetts (972a-1049a). Her testimony, unchallenged by the defendants, confirms the trying situation faced by families of the retarded and those classified as retarded. The District Court was surely correct in these factual findings and conclusions:

[66]Hobbs, *The Futures of Children* 142 (1975) (citation omitted).

[67]Testimony of Commissioner Glenn at 997a-1004a.

> Similarly, parents of mentally retarded children are frequently subject to community pressure to institutionalize their children. Other personal pressures, such as the parents' own emotional difficulties in dealing with the mentally retarded child, as well as the financial problems of providing necessary care, may cause a parent to institutionalize a mentally retarded child although that course is not in the child's best interests. Finally, the parents simply may not be aware of less drastic alternatives to institutionalization (1069a, notes omitted).

In the case of the mentally retarded and their parents, when the question is institutionalization, there is no identity of interests which may be presumed.

The Test in the Danforth Case Accommodates the Interests Involved

The decision of the lower court that parents' and guardians' interests do not negate the rights of young persons in the mental commitment context is manifestly correct.[68] Where parents and guardians seek

[68]The District Court and defendants approach the issue as one of parental power to "waive" minors' rights. While the result is the same, plaintiffs do not believe that the constitutional concept of waiver is relevant here. There is no case in which parents have been found to have waived or not to have waived the constitutional rights of their children. *Gault* discussed the issue of waiver with the Court noting that problems might arise "depending on the age of the child and the presence and competence of the parents." 387 U.S. at 55. *See Heryford v. Parker*, 396 F.2d 393, 396 (10th Cir. 1968) (issue described but not decided).

In plaintiffs' view, the critical question is whether juveniles can be deprived of their rights where parents and guardians assert

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confinement of young persons in mental institutions, there are no significant interests which overcome the right to minimal due process protections.

The factual and legal status of parent-child relations in mental commitment is summarized by the District Court in these telling words:

> There may be instances where the congruence between the parents' interests and those of the child assure that the parents will arrive at a decision based upon the best interests of the child. The evidence in this case overwhelmingly demonstrates that, due to the substantial potential for conflict between the interests of the parent and the child, this is not such a situation.[69]

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contrary and divergent rights. As discussed in the text *infra*, this approach is consistent with that followed by this Court in the parental consent to abortion cases where an inquiry was not made into parental competence to "waive" the rights involved.

Should the Court undertake to consider the waiver issue, plaintiffs submit that parental application for state commitment without more cannot be considered a valid waiver of a young person's rights to counsel and an opportunity to be heard. A waiver of constitutional rights must be made "voluntarily, knowingly and intelligently." *Miranda v. Arizona*, 384 U.S. 436 (1966). There must be an 'intentional relinquishment or abandonment' of a fully known right." *In re Gault*, 387 U.S. 1, 42, quoting *Johnson v. Zerbst*, 304 U.S. 458, 464 (1938).

A valid waiver may not be presumed from the silence of the person involved. *Miranda v. Arizona, supra; In re Gault, supra*, 387 U.S. at 34. In cases involving juveniles, even apparent waivers have been invalidated. *E.g., Haley v. Ohio*, 332 U.S. 596, 601 (1948).

[69]Opinion at 1077a (note and citations omitted). As the District Court indicates, *id.* at n. 44, this case does not present the difficult question of whether parents would have the right to "waive" the constitutional rights of their children, absent seriously conflicting and divergent interests.

The required constitutional analysis refutes defendants' argument that parents must be "in control of the situation" and permitted to waive young persons' Fourteenth Amendment rights. Brief for Appellants at 38.

In *Planned Parenthood of Missouri v. Danforth*, 428 U.S. 52 (1976), finding a protected liberty interest for minors, the Court proceeded "to examine whether there is any significant state interest in conditioning an abortion on the consent of a parent or person in loco parentis that is not present in the case of an adult." *Id.* at 75. This is the test which must be applied in the case at bar.

A direct and persuasive response to *Danforth* is that, as demonstrated above, the constitutional interest in freedom from physical confinement without due process admits of no exceptions. No asserted state interest in any previous decision of this Court has overcome this "liberty," no matter how rehabilitative or treatment-oriented the institution of confinement has been. Those cases, however, did not involve a parent or guardian acting to secure confinement.[70]

The state here, citing no decision of this or any other court, makes a succinct argument that the state's interest is parental autonomy, expressed by medically-

[70]The concurrence of a doctor or hospital in the action is of no constitutional significance under the *Danforth* test. Under *Danforth* and *Bellotti v. Baird*, 428 U.S. 132 (1976), agreement by a doctor to perform a medical procedure does not diminish or negate the asserted constitutional interest (in those cases, the interest of the parents). Further, as the decisions of this and other courts demonstrate, reliance on medical certification to justify mental commitment, absent a hearing and other protections, will not satisfy due process.

advised deprivation of young persons' liberty. Brief for Appellants at 37-38.

Such an argument was expressly rejected in *Danforth* where the young person and parent "are so fundamentally in conflict and the very existence of the pregnancy already has fractured the family structure." 428 U.S. at 75. "Any independent interest the parent may have . . . is no more weighty than the right of privacy of the competent minor mature enough to have become pregnant." *Id.* Likewise, any parental right to obtain mental health care for a child[71] is no more weighty than the liberty right of a child proposed for

[71]Mental institutionalization can hardly be considered run-of-the mill general medical care. No court or legislature has ever considered it such. *See, e.g.*, discussion of Pennsylvania legal history, *infra* at §II.B., and cases cited at 36-38 *supra*. The lower court explained:

> Unlike other kinds of medical treatment, a substantial stigma attaches to institutionalize. This stigma coupled with the substantial danger of error in the diagnosis of mental illness and mental retardation, and the greater potential for long-term loss of liberty create a situation substantially different from the treatment of other parent-child medical conditions. Furthermore, we perceive little or no parent-child conflict in the decision to give or withhold other kinds of medical treatment since a parents' interests are more likely to be similar to the best interests of the child.

1077a-1078a. To the extent that mental health care is considered similar to other medical care, the right of parents to impose it must be considered in light of the risks to the child. *See, e.g., Jehovah's Witnesses in State of Washington v. King County Hospital Unit No. 1 (Harborview)*, 278 F.Supp. 488 (W.D. Wash. 1967), *aff'd*, 390 U.S. 598 (1968), *rehearing den.*, 391 U.S. 961 (1968) (parents sued on "right to decide what medical treatment they will accept for their children;" blood transfusion case). *See also* cases cited *supra* at n. 44.

institutionalization. It is the "absolute limitation on the minor's right," 428 U.S. at 90 (Stewart, J. and Powell, J., concurring), with no provision for "judicial resolution of any disagreement," *id.*, which causes the greatest risk of harm to the juvenile and involves the least benefit to legitimate state interests. *See Bellotti v. Baird*, 428 U.S. 132 (1976).

Under the *Danforth* test, a countervailing significant state interest must be established by more than the unsubstantiated declaration of its existence. *Carey v. Population Services International*, 431 U.S. 678 (1977). Here, the record provides no support whatsoever for the bare assertion of a "parental autonomy" interest in appellants' brief.

Other possible rationales for differentiating between the rights of young persons and adults are neither asserted by the defendants nor present in these circumstances.[72]

The critical question raised by *Danforth* is not *"when rights conflict, which are paramount?"* but *"when presumed common interests in fact diverge, how can each be accommodated and protected?"* There is a

[72]For example, the Court has on occasion looked to minors' vulnerability to harm and their lack of mature judgment in making decisions for themselves. *See, Prince v. Massachusetts*, 321 U.S. 158, 169 (1944); *Ginsberg v. New York*, 390 U.S. 629, 636-637, 649-650 (1968); *Danforth, supra*, 428 U.S. at 102 (Stevens, J., concurring in part and dissenting in part); *Carey, supra*, 431 U.S. at 693, n. 15.

The state interest in assuring emergency mental health care for young persons is protected by the District Court's denial of a pre-commitment hearing and allowance of temporary detention initiated by parents or guardians without a hearing (800a-801a, 1092a).

continuum of decisions made by parents and guardians regarding their wards. At one end are constitutionally trivial and intra-familial issues (what color shirt to wear, what friends to allow into the home) in which there is little, if any, potential harm to the child. Along the continuum, parental powers are met with limits as their interests and desires diverge from those of young persons, in whom the state has an interest (*e.g.*, compulsory school attendance, vaccinations, First Amendment limits). As the parents' claims threaten to risk or unduly interfere with the child's (abortion, blood transfusions), the divergence becomes so great that the parents' assertion of rights is not permitted to overshadow the social necessity of protecting young persons' independent interests. At the extreme end of the continuum are actions which society prohibits entirely as between parents and children (incest, physical abuse, neglect).[73]

When viewed in terms of its nature and potential for harm, mental institutionalization—whether the commitment is erroneous or not—is an event near the end of the continuum at a point where the "parental autonomy" claims are properly muted to the extent necessary to protect the "liberty" claims of the child who is being removed from the home and placed in an institution. Therefore, following the reasoning in other cases where the independent rights of minors have been protected in the absence of a guardian with common

[73]For another extreme situation, in which parents were limited in their right to remove a child from the home, *see Respublica v. Keppelle*, 2 U.S. 197 (Pa.Sup.Ct.), holding that a parent could not bind a child out as a servant.

non-divergent interests,[74] the District Court held that

[74]*See, e.g.*, cases cited *supra* at note 44; *Jehovah's Witnesses in State of Washington v. King County Hospital Unit No. 1 (Harborview)*, 278 F.Supp. 488 (W.D. Wash. 1967), *aff'd*, 390 U.S. 598 (1968), *rehearing den.*, 391 U.S. 961 (1968) (court rejected parental "right to decide what medical treatment they will accept for their children" and "right to decide what medical treatment they will accept for their children" and "right to family privacy" in class action by parents); *Marsden v. Commonwealth*, 227 N.E.2d 1 (Mass. 1967) (child does not have adequate independent representation from parent where parent is complainant in stubborn child proceeding, although parent may have child's best interests in mind); *A.L. v. G.R.H.*, 325 N.E.2d 501 (Ind.App. 1975) (parent lacks power to secure sterilization of son, despite sincere belief in benefits of procedure). In a recent case holding that parents may not admit retarded children to a private hospital for sterilization, absent a hearing, the *Danforth* analysis suggested here was made. *Ruby v. Massey*, 452 F.Supp. 361 (D. Conn. 1978). A court's comments in a civil rights suit by institutionalized retarded children illustrates the approach in these cases:

> I cannot be insensitive to the probability that the interests of the parents may conflict with those of the children residing at the Beatrice State Home. While the parents in all good conscience may desire one remedy, or a specific type or style of treatment for their children, it would not necessarily be in the best interests of the children. Therefore, it seems to me that a discreet course would be to provide for the appointment of a guardian ad litem, who would not displace the parents as representatives of the plaintiffs but would be alert to recognize potential and actual differences in positions asserted by the parents and positions that need to be asserted on behalf of the plaintiffs.

Horacek v. Exon, 354 F.Supp. 71, 74 (D. Neb. 1973).

This Court has had experience with cases in which the property rights of minors have been protected by representation independent of the guardian. *Insurance Company v. Bangs*, 103 U.S. 435 (1880); *United States v. Dunn*, 268 U.S. 121 (1925); *Clarke v. Clarke*, 178 U.S. 186, 193-195 (1900). *See also United*

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"parents may not waive the constitutional right of their child not to be deprived of liberty without due process of law." (1086a).[75]

D. Reliance Upon Psychiatrists and Other Professionals to Authorize Commitment is Misplaced.

Although maintaining that parents must be "in control" of the commitment of young persons to mental institutions, defendants point to the "joint decision" by parents and physicians as a fail-safe that sufficiently protects the interests of the plaintiffs. Examination of the relevant law and facts reveals the phantom character of this asserted protection.

(footnote continued from preceding page)

States v. Equitable Trust Company of New York, 283 U.S. 738 (1931) (in lower courts, one court-appointed guardian acted to protect mentally incompetent person from actions of wife and another court-appointed guardian).

[75]*Accord, J.L. v. Parham*, 412 F.Supp. 112 (M.D. Ga. 1976), *prob. juris. noted*, 431 U.S. 936 (1977); *Kidd v. Schmidt*, 399 F.Supp. 301 (E.D. Wis. 1975); *Saville v. Treadway*, 404 F.Supp. 430 (M.D. Tenn. 1974); *In re Long*, 25 N.Ca.App. 702, 214 S.E.2d 626 (1975); *In re Roger S.*, 141 Cal.Rptr. 298, 569 P.2d 1268 (S.Ct.Cal. 1977). These issues have been discussed in the literature. Wilson, *The Rights of Adolescents in the Mental Health System* (1978); Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions*, 62 Calif. L. Rev. 840 (1974); Teitelbaum & Ellis, *op. cit. supra* note 51.

Mere approval by psychiatrists cannot support a mental health commitment to an institution. *See* discussion and cases cited at 36-39 *supra*. Certainly, the state of the art of psychiatry is not such that the confinement of tens of thousands of persons should be left to the judgment of these practitioners.[76] This field is beset with "uncertainty of diagnosis" and "tentativeness of professional judgment." *Greenwood v. United States*, 350 U.S. 366 (1956); *O'Connor v. Donaldson*, 422 U.S. 563, 579 (1975) (Burger, C.J., concurring).[77]

Mental illness is defined by the user of the term and that definition depends upon the norms employed by the definer:

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[76]This case does not involve second-guessing a "medical diagnosis" or interference with the provision of standard medical care to juveniles. First, with regard to the retarded, retardation is not a medical problem and is not treated medically. *See* 979a-982a; *Halderman v. Pennhurst State School and Hospital, supra* note 31 (differences between mental illness and mental retardation, and their treatments, described). Second, with regard to both mental retardation and mental illness, it is only when medical and other recommendations result in a deprivation of liberty, non-medical risks and imposition of stigma that, as in the case at bar, the protections of due process are triggered. *See* note 71 *supra*. For a detailed review of the literature, *see* Morse, *Crazy Behavior, Morals, and Science: An Analysis of Mental Health Law*, 51 S. Calif. L. Rev. 527 (1978).

[77]One important study showed that diagnoses by psychiatric residents were highly influenced by the imagined socio-economic status of the patient and by the perceived diagnosis of other psychiatrists *independent* of the clinical picture presented. Lee & Temerlin, *Social Class, Diagnosis and Prognosis for Psychotherapy*, in *Psychotherapy: Theory, Research and Practice* 181 (1970); Ennis & Litwack, *Psychiatry and the Presumption of*

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> And, because of the unavoidably ambiguous generalities in which the American Psychiatric

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Expertise: Flipping Coins in the Courtroom, 62 Calif. L. Rev. 693 (1974) (full review of the literature and legal implications); Beck, *Reliability of Psychiatric Diagnoses: A Critique of Systematic Studies*, 119 Amer. J. of Psychiatry 210 (1962); Chesler, *Women and Madness* (1972) (Chapter 2, "Asylums"); Edelman, *Inter-Therapist Diagnostic Reliability*, 25 J. of Clinical Psychology 394 (1969); Goldberg & Werts, *The Reliability of Clinicians' Judgments: A Multi-Trait—Multi-Method Approach*, 30 J. of Consulting Psychology 199 (1966); Katz, Cole & Lowery, *Studies of the Diagnostic Process: The Influence of Symptom Perception, Past Experience and Ethnic Background in Diagnostic Decisions*, 125 Amer. J. of Psychiatry 937 (1966) (44 experienced psychiatrists viewed a filmed interview with a patient. 17 saw the person as psychotic, 26 saw the patient as non-psychotic. When British and American psychiatrists were compared, the British saw less pathology); Pasamanik, Divity & Lefton, *Psychiatric Orientation and Its Relation to Diagnosis and Treatment in a Mental Hospital*, 116 Amer. J. of Psychiatry 127 (1959); Rosensweig, et al., *A Study of the Reliability of the Mental Status Examination*, 117 Amer. J. of Psychiatry 1102 (1961).

"Just as serious obstacles to the diagnostic and therapeutic process arise within the patient, they also arise within the therapist." Nicholi, *The Therapist-Patient Relationship*, in Nicholi, *The Harvard Guide to Modern Psychiatry* 3, 12 (1978). These obstacles, which can become "destructive" to the sensitive relationship between the therapist and the patient or prospective patient, include anxiety within the therapist (which may cause "blind spots" in hearing or understanding the patient's story), professional insecurity, fatigue, impatience "involving excessive eagerness to make the diagnosis," inattentiveness, restlessness, daydreaming, inappropriately intense feelings toward the patient. *Id.* at 12-16.

> Association describes its diagnostic categories, the diagnostician has the ability to shoehorn into the mentally diseased class almost any person he wishes, for whatever reason, to put there.

Livermore, Malmquist & Meehl, *On the Justifications for Civil Confinement*, 117 U. Pa. L. Rev. 75, 80 (1968).[78]

The defendants' extraordinary claim that mental commitments involve no determinative factual questions or disputes flies in the face of every mental commitment decision of this or any other court, the

[78] *See*, Roth, Dayley & Lerner, *Into the Abyss: Psychiatric Reliability and Emergency Commitment Statutes*, 13 Santa Clara Law. 400, 403 (1973). More than a hundred years ago a court noted that commitment of children to reform school was based on differing perceptions of "poor parental care:"

> . . . there is not a child in the land who could not be proved, by two or more witnesses, to be in this sad condition.

People ex rel. O'Connell v. Turner, 55 Ill. 280 (1870). The situation is the same today regarding young persons who can be proved to be in the "sad condition" of mental disturbance. *See* Duehn, *The Effect of Practice Orientations on Clinical Assessment*, 46 Amer. J. of Orthopsychiatry 629 (1976) (extent of negative mental health labeling is determined, in part, by factors extraneous to patients' behavior); Rosenhan, *The Contextual Nature of Psychiatric Diagnosis*, 84 J. Abn. Psychology 462 (1975):

> Despite the DSM-II's attempts to elaborate symptomology associated with each disorder, behaviors are too variable and their meanings too dependent on contextual perception for them to be captured under the rubrics proposed by the DSM-II. The very ambiguity of behavior, the fact that its meanings are not automatically transparent, defeats such attempts at classification from the onset, at least within the psychiatric hospital.

histories of the named plaintiffs,[79] the record in the case,[80] and the voluminous medical literature.[81] The very existence of "mental illness" and the need for institutional care are, as the lower court found, facts which are subject to dispute and not amenable to purely medical determination. *See Specht v. Patterson*, 386 U.S. 605 (1967); *Baxstrom v. Herold*, 383 U.S. 107 (1966). *See also, Danforth, supra*, 428 U.S. at 104 (Stevens, J., concurring in part and dissenting in part) ("Similarly, even doctors are not omniscient. . . . In each individual case factors much more profound than a mere medical judgment may weigh heavily in the scales.").

Institutional psychiatrists are faced with conflicts of interest—with their facilities,[82] with their parents and their patients' families[83]—and have great difficulty

[79]What brought each named plaintiff to the institution and what suggested to the parent and professional a need for institutional treatment was not internal disturbances in thought or feeling but external behaviors and expressions which might or might not have actually occurred and which might or might not have a "normal" explanation. *See* notes 77 and 78 *supra*; LeBow, *Evaluating the Seriousness of Adolescent Adjustment Reactions*, 2 Primary *Care* 281 (1975). *See* Morse, *op. cit. supra* note 76.

[80]*See* notes 53-60 *supra*.

[81]*See* notes 75-78 *supra*.

[82]*See* testimony of Dr. Messinger at 629a-630a (pressures on psychiatrists to confirm colleagues' opinions and meet institutional needs) and Dr. Ingall at 599a (overcrowded clinics may overrecommend institutionalization).

[83]*See* Scheff, *Being Mentally Ill: A Sociological Theory* 148-149 (1966) (commitment is generally automatic where family requests it). Scheff also discusses a case in which a psychiatrist recommended a commitment for a young person who was *not*

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telling the sane from the insane, tending toward an overdiagnosis of mental illness.[84] Psychiatry, asked to adjudicate interpersonal and societal conflicts, is often called upon to be the agent of the state's police powers in ways that carry it beyond its recognized expertise.[85]

What is said above for psychiatry and mental illness is mirrored for mental retardation. The uncontradicted testimony and unchallenged factual findings reflect that "there are many mistakes" in identifying the retarded (981a) through confusion with physical characteristics or handicaps, testing problems, incorrect develop-

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thought mentally ill but who was having difficulties with his parents. *Id.* at 147. Where parents seek commitment of their child, the medical authority is forced into a conflict situation:

> While the goal of the psychiatrist will be expressed—and perceived—as the best welfare of the child-patient, it is the parent who has come to seek help, whose situation seems the most desperate, who seems the most reliable source of information about what is wrong, who is the closest to the psychiatrist in age and social outlook, and who is paying the psychiatrist's fee.

Ellis, *Volunteering Children, supra* note 75, 62 Calif. L. Rev. at 868 (note omitted). This view is confirmed by the expert testimony for all parties. *See* testimony of Dr. Feiner at 472a, 478a-479a; Dr. Sugar at 381a; Dr. Masterson at 732a-733a; Dr. Kandler at 542a; Dr. Ingall at 593a-594a; Dr. Messinger at 637a-638a.

[84]*See* Rosenhan, *On Being Sane in Insane Places*, 13 Santa Clara Law. 379 (1973), discussed in original opinion at 804a, n. 20. Indicative of this approach is the testimony for the defendants by Dr. Masterson who asserted that psychiatrists should first assume that the person before them is mentally ill (739a). *See* testimony at 737a-738a.

[85]*See*, Bazelon, *Forward, Symposium: Mental Illness, the Law and Civil Liberties*, 13 Santa Clara Law. 367 (1973); Szasz, *Civil Liberties and the Mentally Ill*, 9 Clev-Mar. L. Rev. 399, 407 (1960).

mental speculations, and the like (979a-983a, 1068a).[86] "[I]n many cases, people grow out of being retarded." (983a). Therefore, a history of mental retardation is not an infallible indicator or present retardation (982a).

Parents of retarded children receive consultation from professionals they consult, typically physicians other than psychiatrists. The physicians' advice is critical in the decision to institutionalize the child and, tragically, that advice is typically uninformed, without

[86]Mental retardation, by definition, consists of subaverage intellectual performance combined with behavioral maladaptation (979a). Grossman, ed., *Manual on Terminology and Classification in Mental Retardation* (1973). An assessment of behavior is thus a *sine qua non* of a finding of retardation. *Id.* On the intellectual aspect of the definition, serious questions have been raised regarding the accuracy of the tests used. *See, e.g.*, Mercer, *Labeling the Mentally Retarded* (1973). Erroneous diagnoses of mental retardation are not unusual. *See* Menolascino, *Emotional Disturbance and Mental Retardation*, 70 Amer. J. of Mental Deficiency 248 (1965). A web of circumstance, not intellectual functioning level, determines who is committed and who is not:

> Q. Well, isn't there, as I think many people believe, some relationship between a person's IQ or level of retardation and whether or not they are found in an institution?
>
> A. No, not at all. The people you find in institutions now, the reasons range from the parents don't want to let them come out or inappropriate reasons that they have been put in there. * * * It is circumstantial as to whether or not they have ended up in institutions.

Testimony of Commissioner Glenn at 980a-981a. Factual disputes arise in grounds asserted as the basis for commitment of the retarded (998a).

reasonable basis, and inappropriately and excessively oriented toward institutionalization.[87]

In some ways more than in the mental health area, mental retardation professionals who work in institutions are subject to pressures and conflicts of interest which make it impossible for them to independently evaluate people's need for commitment.[88] This occurs

[87]Literature collected in Teitelbaum & Ellis, *op. cit. supra* note 51. *See* Turnbull & Turnbull, eds., *Parents Speak Out: Views from the Other Side of the Two-Way Mirror* (1978) (accounts by retarded children's parents who are mental retardation professionals themselves); Kelly & Menolascino, *Physicians' Awareness and Attitudes Toward the Retarded*, 13 Mental Retardation 10 (1975); Testimony of Commissioner Glenn at 1004a, 1009a.

[88]Several pressures and conflicts are described in Commissioner Glenn's testimony at 1007a-1008a:

> First, there is a basic conflict of interest for somebody in the institution to make a decision about whether or not a person ought to go to that institution. That would be sort of like a store owner deciding whether or not a customer ought to come into his store or somebody else's store. Institutions, as I indicated earlier, are sort of fighting to prove their necessity and justify their existence. All the research in the past 35 years has shown that institutions are not appropriate for the developmental growth of mentally retarded persons, but there are a lot of people that continue to try to justify their existence and the only way they can do that is by having a population. With the move Federally and by states and professions that recognize the inadequacy of this historic institutionalization having a dramatic move toward deinstitutionalization, there is a real conflict where institutions have to have people to prove they should still be around.
>
> Another reason is the institutions, in the vast majority of cases, if not all the cases, would be ignorant of the other alternatives to someone being placed in their institution. Their responsibilities, obviously, would be the operation of that particular program.
>
> Also, the staffs of institutions by the very fact that they work there, think that they are doing the right thing, think

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"regardless of the goodwill or good faith of the institutional staff." (1008a). Psychologists, social workers, educators, and various social agencies often recommend institutionalization even though they may be aware that other alternatives would be more appropriate (1009a-1010a). Overcrowded clinics "very often" overrecommend institutionalization of the retarded (1010a).

E. The Requisites of Due Process.

The requirements of due process are flexible and depend upon an evaluation of the effect of government action on the private interest involved and of the risks and value of alternative procedures, as well as consideration of the government's interest. *Cafeteria Workers Union v. McElroy*, 367 U.S. 886, 895 (1961);

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> that they are the best place for people, and so everybody gets ego involved in what they are doing and have been doing for years and think only they can do the right job.
>
> Thus, an institution staff making a decision would naturally have a tendency toward saying people belong right there in their institutions.
>
> There is also the issue of institutional staff having a mentality of over-protectiveness, really feeling a person has to be brought into the institution and serviced by their staff and protected in that type of environment or the staffs wouldn't necessarily work there.

See testimony at 1008a ("superintendents start sneaking people in, to make sure they can get the same amount of money next year, same census on the rolls. . . .").

Mathews v. Eldridge, 424 U.S. 319, 335 (1976).[89] Notice, counsel and an opportunity to be heard are fundamental requirements where a deprivation of personal liberty—for whatever reason—is involved. *E.g., Specht v. Patterson*, 386 U.S. 605 (1967); *Baxstrom v. Herold*, 383 U.S. 107 (1966); *In re Gault*, 387 U.S. 1 (1967).

The limits of the process found due by the lower court deserve renewed emphasis at this point.[90] With the exception of notice of prolonged commitment and counsel or other trained representative, all rights may be waived, including presence at any hearings. It is expected that hearings will not be required in every case; a large number of hearings will be waived.[91] The forum for hearings which are held would be an "impartial tribunal" where the perspective and con-

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[89] *Mathews v. Eldridge* requires consideration of three concerns:

1. The private interest that will be affected by the official action. The right to be free from confinement in an institution and the consequences of such confinement—whether erroneous or not—have already been discussed.
2. The risk of erroneous deprivation through the procedures used and the probable value of substitute procedures. The inherently substantial risk of error in reliance on parental or professional decision-making is discussed above. The value of substitute procedures is discussed in this section of the brief.
3. The government's interest, including fiscal and administrative burdens, is discussed in this section of the brief.

[90] *See* discussion *supra* at 19-21.

[91] *Id. See* 811a, n. 26.

cerns of the parents or guardians could be fully aired.[92]

Many states provide hearings for young persons facing commitment.[93] Seven states make no distinctions among age groups in their commitment laws: Alabama, Alaska, Connecticut, Minnesota, Nebraska, New Hampshire and Virginia. Florida makes no

[92]The process is consistent with that urged by Professor John P. Wilson, Associate Dean, Boston University School of Law, in his new volume, *The Rights of Adolescents in the Mental Health System* 222-223 (1978):

> In view of this situation, due process seems to demand procedures which can be invoked by interested parties but which for the most part are not automatically applied in every admission. Where no one, including the child, objects to the arrangements being made, there seems no reason to disrupt the parent-child relationship beyond a review of the good faith and informed consent of all competent parties involved and periodic review of the need for hospitalization and treatment. On the other hand, in view of the possible abuses of the voluntary admission process and the growing independence and maturity of a juvenile child, procedures should be available to the need for admission whenever that child or another interested party raises an objection.
>
> One method of accomplishing this delicate task would be to inject an independent third party into the situation—an advisor and advocate for the child whose presence and assistance could not be waived by the parents. This person would counsel the child, and if the child then objected to admission or was incompetent to consent to admission, would represent him or her in a hearing, probably before a multidisciplinary review board. Ultimate appeal to a court would be possible. The review board would be responsible for either authorizing or denying admission once an objection was raised. Thus in contested cases this board would effectively perform the decision-making function now performed, in most states, solely by parents and an admitting physician.

[93]Wilson, *op. cit. supra* note 75, Appendix B, 301-308. The state-by-state information in the text is summarized from this appendix.

mention of parental authority to commit persons under 12. In three states, Rhode Island, Tennessee and Texas, the minor must consent to the commitment. In Iowa, South Dakota and Montana, an objecting minor receives a hearing, as do objecting minors 13 and older in Michigan. In Illinois and Montana, court approval is required for extended commitment, whether the minor objects or not (as noted previously, an objecting Montana minor receives a hearing). In the 35 other states, statutes require parents or guardians to consent to institutionalization.[94]

The record in this case and the findings of the lower court support a number of important practical observations concerning the need for and functions of commitment hearings for young persons.

Opportunity for a hearing for juveniles is proper and necessary in non-emergency situations.[95] Because of their immaturity and lack of experience, it is even more important that juveniles receive the protection of a hearing than adults.[96] Assistance of counsel is essential and can help treatment of juveniles; in no significant way could it hinder such treatment.[97] As the lower

[94]Two of those states, California and Wisconsin, have had their statutes invalidated, in whole or in part, by recent litigation. *See* note 75 *supra*.

[95]*See* testimony of Dr. Kandler at 542a-545a, 566a, 571a-572a, 573a-574a; Dr. Ingall at 596a-597a, 606a; Dr. Messinger at 622a-623a, 625a, 630a-631a; Dr. Feiner at 479a-480a; Commissioner Glenn at 1011a.

[96]*See* testimony of Dr. Kandler at 562a; Dr. Ingall at 589a-590a; Dr. Messinger at 630a-631a.

[97]*See* testimony of Dr. Kandler at 542a-543a; Dr. Ingall at 597a; Dr. Messinger at 633a.

court found, a hearing would not be unduly traumatic for juveniles and would not interfere with treatment or the parent-child relation; to the contrary, a hearing would encourage more appropriate resolution of problems and would have positive and beneficial effects on the child and his or her parents.[98] *See In re Gault, supra*, 387 U.S. at 26.[99]

Establishment of a due process impartial forum for a decision to institutionalize lifts the heavy responsibility from the parents[100] and reduces the possibility that the therapist will be seen by the juvenile as an adverse party.[101] A hearing does not interfere with therapy and has the further effect of encouraging a juvenile's cooperation with a treatment plan.[102] The opportunity for hearings would not discourage people from seeking treatment for juveniles (although it would, no doubt, deter unwarranted applications) but would result in agencies and professionals performing more effectively, the avoidance of the necessity for hearings, reduced use of institutionalization, and the

[98]Opinion at 1081a-1082a. *See* testimony of Dr. Kandler at 543a-545a, 565a-566a, 574a; Dr. Ingall at 591a, 596a-597a, 611a-613a; Commissioner Glenn at 1012a, 1013a-1015a, 1024a-1025a.

[99]Dr. Feiner testified that ". . . it has been said that some children would rather be fair than be loved. So, there is a sense that a judicial hearing responds to in children" (483a). *See* testimony of Dr. Messinger at 624a.

[100]Testimony of Dr. Feiner at 481a, 495a; Commissioner Glenn at 1013a-1014a.

[101]Testimony of Dr. Messinger at 624a-625a; Dr. Ingall at 612a-613a.

[102]Testimony of Dr. Kandler at 561a, 574a; Dr. Ingall at 597a; Dr. Messinger at 633a.

provision of more appropriate care in particular cases.[103]

Notice. Turning to the specific procedural protections recognized by the lower court, the first is notice of a commitment which is to last longer than three days. Without advance notice, the fundamental "right to be heard has little significance."[104] In mental commitment cases, notice is at least as essential, if not more so, than in proceedings which do not result in deprivation of liberty. *Cf., Goldberg v. Kelly*, 397 U.S. 254 (1970). Where a proceeding will be held which will determine whether a person is indeterminately and involuntarily institutionalized, advance notice is imperative.

The speculative fear of an unspecified trauma flowing from notice cannot justify abandonment of this first step in providing a process which is due under the circumstances. *In re Gault, supra*. In its comprehensive study, the American Bar Foundation noted:

> The humanitarian desire to eliminate or curtail the use of notice in such cases raises certain questions, however. It may be, for example, that the experience of receiving notice would prove no more traumatic for the patient than the experience of suddenly finding himself detained in a mental institution.[105]

[103]*See* testimony of Dr. Kandler at 574a; Dr. Messinger at 638a-640a; Dr. Feiner at 494a-495a; Commissioner Glenn at 1014a-1015a.

[104]Opinion at 802a, citing, *inter alia, Grannis v. Ordean*, 234 U.S. 385, 394 (1914); *In re Gault*, 387 U.S. 1 (1967); *Mullane v. Central Hanover Trust Co.*, 339 U.S. 306 (1950).

[105]American Bar Foundation (Brakel & Rock, eds.), *The Mentally Disabled and the Law* 51 (1971). "Since effective notice is a prerequisite to the exercise of an individual's other due

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Counsel. In criminal proceedings, *Argersinger v. Hamlin*, 407 U.S. 25 (1972), and in juvenile proceedings, *In re Gault, supra*, the guiding hand of counsel is a right which assures that no person is deprived of liberty without the aid of an expert able to "cope with problems of law, to make skilled inquiry into the facts, to insist upon regularity of the proceedings and to ascertain whether he has a defense and to prepare and submit it." *In re Gault, supra*, 387 U.S. at 36.

The lower court recognized that it "may not always be necessary to appoint a lawyer so long as a substitute

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process rights, mandatory notice should itself be a requirement of due process" in mental health cases. Note, *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 Harv. L. Rev. 1190, 1274-1275 (1974) (notes omitted). Eighty years ago, in a landmark and often-cited case, the Kansas Court of Appeals explained the logic of requiring notice in mental commitment proceedings:

> Notice and opportunity to be heard lie at the foundation of all judicial procedures. They are fundamental principles of justice which cannot be ignored . . . it will not do to say that it is useless to serve notice on an insane person; that it would avail nothing because of his inability to take advantage of it. His sanity is the very thing to be tried.

In re Wellman, 3 Kan. App. 100, 103, 45 P. 726, 727 (1896).

Consider how differently the commitment of Edward B. would have been had he been given notice under the court's order. Rather than arriving at the institution and being informed that he would be there indefinitely, after being "tricked" by his parents into coming and after being made to feel "like a prisoner," he would have been told that, if he had to stay longer than a few days, he would have a lawyer or other representative to help him out and that he could have a chance to tell his side of the story to a neutral party. The positive effect on Edward B.—and the plaintiff class as a whole—is readily apparent.

procedure adequately protects the child's interest," for example, a guardian who might, if necessary, "have the power to retain a lawyer." (1079a, n. 47). This flexibility permits informality and allows a minimum of legal technicality while assuring that, where legal expertise is essential, it is provided.

Mandatory appointment of counsel or other trained representative in juvenile commitments assures that a child has the full support necessary to avoid pressures of family and institutions and provides assistance in making the critical decision whether to waive an evidentiary hearing. *See Gallegos v. Colorado*, 370 U.S. 49, 54 (1962); *Haley v. Ohio*, 332 U.S. 596, 599-601 (1948); Harris, *Mental Illness, Due Process and Lawyers*, 55 A.B.A.J. 65 (1969) (noting danger that young persons will be induced to commit themselves to mental institutions unless their rights are explained to them by lawyers). With parents, doctors and institutional staff all urging commitment, and with no independent confidant and advisor, it is impossible to expect a child to make an "intentional relinquishment or abandonment" of a fully known right. *Johnson v. Zerbst*, 304 U.S. 458, 464 (1938). Where the young person is unable to comprehend exactly what is happening, appointment of a conflict-free advocate is even more essential. *See, e.g.*, testimony of Commissioner Glenn at 1019a-1020a.

Hearing. Balancing the young person's liberty interest in a pre-commitment hearing against the interests of the state and parents or guardians, the lower court held that a hearing is not constitutionally required prior to institutionalization (800a-801a).

However, both a probable cause hearing and a full hearing are required (unless waived) within a reasonable period of time in order to support an indefinite mental commitment. *In re Barnard*, 455 F.2d 1370 (D.C.Cir. 1971); *Lessard v. Schmidt, supra* note 34. In order to determine if "the nature and duration of confinement bear some reasonable relation to the purpose for which the individual is committed," *Jackson v. Indiana*, 406 U.S. 715, 738 (1972), a hearing opportunity is indispensable. *See McNeil v. Director, Patuxent Institution*, 407 U.S. 245 (1972).

Impartial Tribunal. Without specifying any requirement for a judicial hearing, and with the implication that an administrative hearing would be sufficient, Opinion at 1082a, n. 53, the lower court states "only that the tribunal must be neutral and unbiased." *Id.* at 1082a. In criminal, quasi-criminal and administrative processes, the right to an "impartial decision-maker" is an "essential" right. *Goldberg v. Kelly*, 397 U.S. 254, 271 (1970); *Gibson v. Berryhill*, 411 U.S. 564 (1973), and *cf., Arnett v. Kennedy*, 416 U.S. 134, 170, n. 5 (1974) (Powell, J.) with *id.* at 196-199 (White, J.) and 216 (Marshall, J.). The probable cause for detaining a person in an institution cannot be determined by the very people who apply for and seek the institutionalization. *Gerstein v. Pugh*, 420 U.S. 103 (1975).

Presence of Person. While the right to be present is not absolute, *Illinois v. Allen*, 397 U.S. 337 (1969), there can be no doubt that persons subject to civil commitment have a right to be present. *Specht v. Patterson*, 386 U.S. 605 (1972). To avoid any trauma to particular individuals, the lower court specifically held

that the child's representative "has the option of waiving the child's presence at the hearing if there is a potential for trauma," 1082a, subject to the tribunal's approval. The right to be present has value to others beside the subject of the proceedings. The individual's appearance provides the factfinder with an opportunity to observe his or her demeanor and to compare observations with those of psychiatrists, other doctors and professionals, parents and other witnesses. *See* Note, *Developments in the Law, supra* note 105, 87 Harv. L. Rev. at 1282-1283. The chance to tell one's side of the story is an essential one.

Rights at the Hearing. The District Court held that "because of the tremendous personal as well as societal loss error might cause," a young person facing involuntary indeterminate mental institutionalization is entitled to "the rights to confront and to cross-examine witnesses against him, to offer evidence in his own behalf and to offer testimony of witnesses. . . ." (810a). These traditional factfinding tools are essential in the commitment process so that conflicts may be resolved and the true state of affairs ascertained. *Specht v. Patterson, supra*, 386 U.S. at 610; *Lynch v. Baxley*, 386 F.Supp. 378, 394 (M.D.Ala. 1974), citing, *Washington v. Texas*, 388 U.S. 14, 19 (1967).

Standard of Proof. The danger of erroneous commitment must be weighed against the dangers of not committing those who may be said to require institutionalization; this is the analysis required to determine the appropriate standard of proof. While in juvenile proceedings, this Court has required a reasonable doubt standard, *In re Winship*, 397 U.S.

358 (1969), lower courts are divided on the standard to be used in the similar mental health context. *See, e.g., In re Ballay*, 482 F.2d 648 (D.C. Cir. 1973) (reasonable doubt); *Lessard v. Schmidt, supra* at note 34 (reasonable doubt); *Suzuki v. Quisenberry, supra* at note 37 (reasonable doubt); *Lynch v. Baxley, supra* at note 37 (clear, unequivocal and convincing); *Dixon v. Attorney General of the Commonwealth of Pennsylvania, supra* at note 37 (clear, unequivocal, convincing). The lower court here adopted the clear and convincing standard, choosing not to follow *Winship* because the undeveloped state of psychiatry "creates too great a risk of erroneously releasing children in need of institutionalization." (809a). This issue is presently before the Court in *Addington v. Texas*, No. 77-5992.

The second part of the *Mathews v. Eldridge* test requires inquiry into whether the above procedures would actually reduce the likelihood of error.[106] Expert

[106]Defendants ingenuously opine that these due process protections will not erase the public's stigmatizing reaction to mental disability and that, in many cases, the tribunal will confirm the recommended institutional care. Due process is not intended to alter public opinion, but to protect children not in need of commitment from the disapprobation which, at this point in history, is the inevitable result of mental commitment. In cases where hearings are not waived, the task is to arrive at a just result, not to tally up an impressive scorecard of "wins" or "losses." Nevertheless, recent studies of commitments demonstrate the ability of courts to make independent judgments. Hiday, *Reformed Commitment Procedures: An Empirical Study in the Courtroom*, 11 Law & Soc'y Rev. 651 (1970); Zander, *Civil Commitment in Wisconsin: The Impact of Lessard*, 1976 Wis. L. Rev. 503, 552. Older studies, such as the one relied on by the

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testimony at trial and the lower court's findings support a positive answer to this question. The traditional purposes of a due process hearing would be served: facts would be sifted, all evidence weighed, and reasons for and against commitment carefully and impartially examined.

A further crucial function of the hearing will reduce another sort of error. There are many young persons who will be found to need care and residential services outside the family home. "The real question in these cases is whether care *in an institution* is required or whether there is some less restrictive alternative which would better meet the individual's needs." Teitelbaum & Ellis, *The Liberty Interest of Children: Due Process Rights and Their Application*, 12 Family Law Quarterly 153 (Fall, 1978).[107]

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defendants, indicated frequent unquestioning reliance on medical recommendations, especially where procedural protections were lax. *E.g.*, Wenger & Fletcher, *The Effect of Legal Counsel on Admissions to a State Mental Hospital: A Confrontation of Professions*, 10 J. Health & Human Behavior 66 (1968) (noting, however, an extremely high statistical association between respresentation by counsel and decision not to commit).

[107]The lower court held that "Where the state sanctions the restriction of a child's liberty rights, such restriction should intrude upon those rights to the smallest possible degree necessary achievement of the purposes of the restriction." (1081a) (citations omitted). This "least restrictive alternative right" is recognized in, *e.g., O'Connor v. Donaldson, supra*, 422 U.S., at 575, citing *Shelton v. Tucker*, 364 U.S. 479 (1960); *Welsch v. Likins*, 373 F.Supp. 487 (D.Minn. 1974); *Halderman v. Pennhurst State School and Hospital, supra; Dixon v. Weinberger*, 405 F.Supp. 974 (D.D.C. 1975); *Covington v. Harris*, 419 F.2d 617 (D.C. Cir. 1969); *Lake v. Cameron*, 364 F.2d 657 (D.C. Cir. 1966).

Explanation of appropriate alternatives for care can meet the needs of both the young person and his or her parents:

> The existence of these alternatives [community-based, non-institutional facilities] means that the placement choice is not a "zero-sum game" in which either the parents or child must "lose." Rather, independent review of the child's needs, the family's needs, and the options available to them may enhance the lives of each.

Id. at ___.

The final application of the *Eldridge* test requires evaluation of the state's interest in avoiding the provision of additional procedures. At the hearing held on the state's stay request, the state was unable to provide any information at all on the number of hearings which might be required or on the costs of implementing the lower court's order. Memorandum of July 17, 1978. Assuming there will be some cost in protecting the constitutional rights of the plaintiffs, the state's interest in protecting its fisc is outweighed here by the private interests and the risk of error, as in similar delinquency and adult mental health contexts. Further, avoidance of institutional care and diversion of some cases to community-based programs will result in substantial cost savings to the state. *See Halderman v. Pennhurst State School and Hospital, supra; J.L. v. Parham, supra*, 412 F.Supp. at 126. Finally, it must be observed that the state has no interest in the erroneous or unnecessary confinement of any of its citizens, irrespective of age.

F. Neither the State's Statutes Nor Regulations Affect the Unconstitutionality of Commitment Without Hearing Before an Impartial Tribunal, Counsel or Other Trained Representative and Other Rights.

The 1966 Act and Regulations

The basic constitutional infirmity of Sections 402 and 403 of the 1966 Act is the failure to guarantee the minimal due process rights specified in the lower court's order and discussed above. Parents and guardians are permitted to institutionalize retarded young persons, simply upon application, with no protection for the child. Such a system cannot stand.[108]

The regulations issued in 1973[109] do nothing to cure the constitutional flaws noted above. Because the legal and operational problems with these provisions are discussed in great detail by the lower court (1083a-1085a) and by the only expert on the retarded to testify (1015a-1023a),[110] they are dealt with in a summary fashion below.

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[108]The constitutionality of the statute alone (without the regulations) is before this Court. George S., Gina S. and Nancy Louise D. were each committed before 1973 when the regulations were promulgated. The regulations did not require that already-commitment persons receive notice of any additional rights (Opinion at 1076a, n. 42).

[109]As the lower court noted (1059a, n. 11), the 1973 regulations apply only to commitment of young persons as retarded under the 1966 Act, and not to commitment of young persons as mentally ill under the 1976 Act (949a-950a).

[110]Commissioner Glenn qualified as an "expert in the area of mental retardation, care and rehabilitation of retardation institutions and community care for the retarded in the United States." (977a). Her paragraph-by-paragrph analysis of the regulations is uncontradicted.

Paragraph 1 of the regulations provides for referral of a retarded juvenile by an agency, pediatrician, general physician or psychologist. The institutional director or delegate, under paragraph 3, conducts an examination. As found by the District Court, the referral sources "may have no knowledge or training whatsoever concerning the problems of mental retardation, while the Director of the Institution, who has interests different from those of the child, may be placed in a position of conflict in making the decision to commit." (1084a, notes omitted). Referrals are often made as a "cop-out" to avoid the effort of alternative placements (1009a, 1084a, n. 57). This referral system is subject to serious abuse:

> One of the patterns of behavior for parents attempting to institutionalize their child has always been a shopping behavior, to shop around until they could get the right words on the right page from whatever physician they could find or psychologist; not just parents, other social agencies, social case workers, welfare workers.

Testimony of Commissioner Glenn at 1016a-1017a.

The referral body's evaluation, confirmed by the institution, is an improper legal basis for commitment. It is unconstitutional for persons to be confined solely on the basis of medical certifications. *See* cases cited *supra* at note 37. *See also, Wyatt v. Aderholt*, 358 F.Supp. 1382 (M.D. Ala. 1973) (sterilization of retarded "cannot be left to the unfettered discretion of any two officials or individuals"). The regulations here codify exactly what the law condemns.

The regulations require a skimpy evaluation, "certainly a limited documentation to make a life-long

decision for a person" (1017a), fail to require any specific reasons for institutionalization (Opinion at 1083a, n. 55), and omit entirely the professional prerequisites for a proper report (1017a-1018a).

For retarded persons under 13, no procedures in addition to the above exist. "There is no assurance whatsoever that the interests of the child will be weighed in making this decision. Therefore, this procedure does not provide the protections furnished by hearing before an 'unbiased tribunal'." (Opinion at 1084a-1085a).

Retarded persons over 13 receive a technical notice of rights about which, the expert testified, "Mentally retarded people would not be able to read the written notification or understand the explanation of his rights or have ever had the opportunity to learn how to use the telephone. . . ." (1019a, Opinion at 1085a).[111]

Those who understand the notice and want to object are "typically afraid to" protest because of the "atmosphere of pressure" in an institution." (1020a). "It's putting an awful lot of burden on young retarded persons to stand up against a big institution. . . ." (1021a).[112]

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[111] The regulations add insult to injury by providing that, if the juvenile is "incapable of understanding," the institutional staff member merely notes that fact on the form, without taking further protective action. (1059a) (Regulations, Par. 8).

[112]

> The fact that a new "patient" may act in a passive manner and not protest should not be taken "to be a meaningful acceptance of commitment."

Cohen, *The Function of the Attorney and the Commitment of the Mentally Ill*, 44 Tex. L. Rev. 424, 447 (1966). *See Haley v. Ohio*, 322 U.S. 596 (1948); *In re Gault*, 387 U.S. 1 (1966). One

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Finally, the regulations do not set a time limit within which a hearing must be held if the retarded child who happens to understand his or her rights is courageous enough to object. It may be one week, two weeks, a month or more for all the regulations neglect to say. Even a short commitment can be dangerous to the individual and, equally important, can cause serious hardship for the parents (1023a).

The 1976 Act

Unadorned by any regulations affecting commitment rights, the 1976 Act permits persons 13 and younger to be volunteered into mental institutions for indefinite periods without "a required post-commitment hearing" and in the "absence of counsel to advocate the interests of the child." (Opinion at 1086a).[113] The statute ignores the obvious fact that the needs of these very young people demand special protection (*see* testimony of Dr. Messinger, quoted at 1086a, n. 61).

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commentator explains the particular need for an advocate for young people facing commitment:

> Because young persons usually are more susceptible to persuasion than are older persons, there is a greater danger that they will be more easily induced to commit themselves voluntarily to mental hospitals unless their rights are carefully explained to them by lawyers.

Harris, *Mental Illness, Due Process and Lawyers*, 55 A.B.A.J. 65 (1969).

[113]The confirmation of the new commitment by an institutional "treatment team" and any accompanying psychiatric/psychological reports provides no added protection, as the lower court observed (1086a, n. 60).

When such institutionalized juveniles object to their confinement or express a desire to leave the institution, as the named plaintiffs have, the defendant institutional directors do not provide counsel or take action to assure either discharge or a hearing on the juveniles objections because the defendants believe they have the right not to take such protective measures (Stipulated at 950a).

Reliance on an unspecified "responsible party" to intrude, evidently by chance, unspecified days or months after commitment, to request a hearing is plainly unacceptable (Section 206(b) of 1976 Act, Opinion at 1086a-1087a). It would be harmful and counter-therapeutic to rely on the speculative possibility of a post-commitment hearing:

> I think it is a most inadequate provision and it is closing the barn door after the horse is out. I think it is disastrous to hospitalize a child and then find out, by golly, it wasn't necessary. That is playing with a child's life.

Testimony of Dr. Messinger at 631a (discussing the post-commitment hearing under the 1973 regulations). *See also* testimony of Dr. Feiner at 482a; Dr. Ingall at 596a.

The procedures for "voluntary" commitment of the subclasses of young persons committed as mentally ill and mentally retarded are unconstitutional on their face and as applied to the twelve named plaintiffs and those they represent.

II.

INDETERMINATE CONFINEMENT OF YOUNG PERSONS IN STATE-LICENSED INSTITUTIONS CONSTITUTES "STATE ACTION" WHERE THE STATE DELEGATES TO PRIVATE ENTITIES THE POWER TO DEPRIVE PEOPLE OF LIBERTY AND, ALTERNATIVELY, WHERE COMMITMENT TO INSTITUTIONS IN PENNSYLVANIA IS A POWER TRADITIONALLY EXCLUSIVELY RESERVED TO THE STATE.

All mental health and mental retardation institutions in Pennsylvania which are not state-owned and operated must be licensed and/or approved by the Department of Public Welfare (949a). Such facilities are required to utilize and act in conformity with the commitment procedures in both the 1966 Act and the 1976 Act. *Id.* As to these state-licensed institutions (and *not* as to state-owned institutions), the defendants suggest to this Court that "state action" for Fourteenth Amendment purposes is lacking.

"State action" is present for these commitments, plaintiffs submit, because (1) the state has delegated to parents, guardians and institutions a power not possessed by the state, the power to deprive persons of liberty without minimal due process procedural protections, and alternatively, (2) power over mental commitments is traditionally exclusively reserved to the state in Pennsylvania.

A. "State Action" Is Present Where the State Delegates to Private Entities a Power Not Possessed by the State, the Power to Deprive Persons of Liberty Without Minimal Due Process Procedural Protections.

Where a state law "puts its power behind,"[114] "places the power of the state behind,"[115] "fosters or encourages,"[116] is a "joint participant,"[117] or is "only one of several co-operative forces" leading to the constitutional violation,[118] otherwise private action is within the reach of the Fourteenth Amendment. It is insufficient if the state merely "authorized and approved" the challenged private action, *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 354 (1974), or if the state decides not to act in a "purely private dispute." *Flagg Brothers, Inc. v. Brooks*, 98 S.Ct. 1729 (1978).

Unlike *Jackson* and *Flagg Brothers*, here the state has affirmatively acted to require every parent or guardian committing a child, and every institution confining a child, to use certain procedures and to act in accordance with the challenged statutes. This is not a private commercial dispute and does not involve mere regulation of private business activities. Unlike *Jackson* and *Flagg Brothers*, a fundamental constitu-

[114] *Gray v. Sanders*, 372 U.S. 368 (1963).

[115] *Anderson v. Martin*, 375 U.S. 399, 402 (1964).

[116] *Moose Lodge No. 107 v. Irvis*, 407 U.S. 163, 176-177 (1972).

[117] *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 357-358 (1974).

[118] *United States v. Guest*, 383 U.S. 745, 755-756 (1966). *See, Norwood v. Harrison*, 413 U.S. 455 (1973), cited with approval in *Jackson, supra* note 117.

tional right—the right to liberty in its core sense—is implicated and the state law explicitly supports and mandates the deprivation of that right without due process.

The *Danforth* and *Bellotti* parental consent to abortion cases rest upon an implicit state action finding where parents are acting under a state law which grants them authority in connection with medical procedures claimed for a child. In that situation, "the State does not have the constitutional authority to give a third party an absolute, and possibly arbitrary, veto," *Danforth*, 428 U.S. at 74, over a child's right. It makes no difference whether the doctors, clinics or hospitals involved in the abortion (or mental commitment) are "private" or "public;" the determinative factor is the state laws's embodiment of parental power to veto a constitutionally protected interest of a young person. Where the state cannot deprive a person of liberty without minimal due process, it cannot delegate that right to a parent or guardian or mental institution.[118a]

B. "State Action" Is Present Where Mental Commitment Is a Power Traditionally Exclusively Reserved to the State in Pennsylvania.

As defendants are evidently unaware, commitment of the mentally disabled in Pennsylvania (since the first

[118a] The only mental health case cited on this issue by defendants has been vacated as moot. *In re John S.*, 135 Cal.Rptr. 893, 901, *vacated as moot*, 66 Cal.App.3d 343 (1977). In any event, that case involved no state action issue, as California "does not control either admissions or treatment policies" at the private institution, and as the court found no state involvement at all. *Id.*

commitment in 1676) has been a "power traditionally exclusively reserved to the State," *Flagg Brothers, Inc. v. Brooks*, 98 S.Ct. 1729 (1978). Parents and guardians never had the power to commit children to non-governmental institutions freely until the 1966 Act was passed. Since private licensed mental facilities were first established, they have all been required to utilize state commitment laws and there has been a "sufficiently close nexus between the State and the challenged action of the regulated entity so that the action of the latter may fairly be treated as that of the State itself." *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 351 (1974). The use of mental commitments, under the law, has been as different from general medical care as black from white.

English Law as Brought to Pennsylvania. Settlement of Pennsylvania by the English brought with it the common law powers of chancery courts over idiots and lunatics. These powers were delegated by the Crown as *parens patriae*. 2 Story, *Commentaries on Equity Jurisprudence* 591 (1836). *See also, M'Elroy's Case*, 6 W. & S. 452 (C.P. Phila. 1843). English chancery procedures involved a petition, an inquisition "which is always had" and trial of the case by a jury. Story, *op. cit.* at 594-595.

Appropriately, the first record of a mental commitment in Pennsylvania involved a parent alleging a child's mental infirmity. In 1676, according to court records of Upland (Delaware) County, a father petitioned for relief from the care of his insane son. The court ordered a "block-house" to be built to confine the son and a tax levied to cover the costs. Deutsch, *The Mentally Ill in America* 42 (2d ed. 1949); 7 *Memoirs of the Historical Society of Pennsylvania* 102-103.

Pennsylvania courts were issuing lunacy and idiocy inquisitions as early as 1728. Pennsylvania (Colony) Court of Chancery, *The Registrar's Book of Governor Keith's Court of Chancery of the Province of Pennsylvania* at 40, Case No. 8 (1728) (creditors sought writ against debtor); *Id.* at 61, Case No. 27 (1734-1735) (father sought writ against son).

Pennsylvania Constitution. When the colony became a state, the sovereign chancery power over "the care of the persons and estates of those who are *non compotes mentis*" was delegated to the courts of common pleas by the Pennsylvania Constitution of 1776, Art. V, §24 (1776). This delegation of a clear exclusive power continued over the following century's three constitutions. Pa. Constitution, Art. V, §6 (1790); Pa. Constitution, Art. V, §6 (1838); Pa. Constitution, Art. V, §20 (1873). *See also, Clark's Case*, 22 Pa. 466 (1854).

Operation of Common Law Writ. As first codified by the legislature in 1836, the mental commitment process applied to both the mentally ill and retarded under its provisions for "lunatics." Act of 13 June 1836, §67, P.L. 605. Upon application to the court, a writ *de lunitaco inquirendo* issued. Notice to the alleged lunatic or to relatives or friends was required. Act of 13 June 1836, §4, P.L. 593. *Relatives or friends seeking a finding of lunacy were not competent to receive notice. Hinchman v. Richie*, 4 Clark 184, 7 Pa.L.J. 268, Brightly N.P. 143 (Phila. 1847). Notice was mandatory. *Comm. ex rel. Stewart v. Kirkbride*, 7 Phila. 8, 2 Brewst. 419 (C.P. 1868).

A commission was then appointed by the court to secure six twelve persons for the inquest into the person's state of mind. Act of 13 June 1836, §§3, 7, P.L. 592, 595. Lunacy was a jury question. *In re Weaver*, 116 Pa. 225, 9 A. 323 (1887). Commissions existed in substantially the same form until 1951.

After a hearing and finding by the commission, the court issued its orders respecting the custody and care of the person and his or her estate. Act of 13 June 1836, §13. Generally a person was confined to the custody of another private party. *Hinchman v. Richie, supra; In the Matter of Kenton*, 5 Binn. 613 (1813); Story, *op. cit.* at 592.

Nobody could be confined in any asylum except after a trial with witnesses and counsel for the alleged lunatic. *Commonwealth v. Spink*, 137 Pa. 255 (1890). One court declared the governing principles in this way:

> It is abhorrent alike to our sense of justice and to all judicial precedent that character, liberty, and estate should be swept away from him without a hearing or opportunity for defence. To hold otherwise would be contrary to every principle of reason and justice.

Comm. ex rel. Stewart v. Kirkbride, 7 Phila. 8, 11, 2 Brewst. 419, 425 (1868).[119] A person before a commission had the rights of a criminal defendant. *In re Lincoln*, 1 Brewst. 392 (C.P. 1867).

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[119] In emergencies, then as now, commitment was permitted on a tempoary basis without a hearing, with delayed compliance with the formalities of the law. *Comm. ex rel. Nyce v. Kirkbride*, 2 Brewst. 400 (C.P. Phila. 1868); *Hinchman v. Richie*, Brightly N.P. 180, 181 (C.P. Bucks Cty. 1847).

Judicial Supervision of Physicians' Certificates. In 1869, an alternative means of institutional commitment was added to what the sovereign state would permit. Two physicians were required to swear out a certification for the mentally ill or retarded person before a magistrate or judicial officer before any confinement could begin. Act of 20 April 1869, P.L. 78; 50 P.S. §42 (1923); 50 P.S. §1181 (1951).[120] Under the law, physicians' certificates could be traversed. *Comm. ex rel. Hembold v. Kirkbride*, 11 Phila. 427 (1876). *See infra*, text at note 121 for traverse procedures.

"Voluntary" Commitment of Adults and Children. No provisions for voluntary institutionalization existed until 1883. *The first such laws related to private institutions* and allowed only a seven day detention

[120]After 1923, one physician was required for the retarded. 50 P.S. §49 (1923); 50 P.S. §181(d) (1951). In 1925, commitment procedures for adults were changed so that retarded adults were committed under the same procedures as retarded children. *See*, 50 P.S. §51 (1923); 50 P.S. §50 (1925), and *see* discussion in text *infra*.

Two other statutory commitment requirements are of note. The legislature explicitly made the certificate procedure necessary for commitment to private institutions. Act of 9 May 1883, P.L. 25. Also, the indigent insane could be sent to institutions by petition of the directors of almshouses, county authorities, and jails. Act of 8 June 1881, P.L. 83; Act of 16 July 1897, §1, P.L. 301; Pa. Laws of 1863, P.L. 540. However, a commission resulting from such a petition would be set aside where it is not shown why the relations did not petition for a commission. *Madden's Lunacy*, 13 D.R. 658, 12 Luz. L. Reg. Rep. 38 (1903).

At least three persons had to be willing to swear to the alleged lunacy. *Metz's Case*, 5 Pa. Dist. Rep. 132 (C.P. Dauphin Cty. 1896).

agreement, executed in the presence of an adult friend and the institution's head. Act of 8 May 1883, P.L. 28-29. Voluntary admission to all hospitals was first provided in the 1923 Mental Health Act, under which, upon written notice, a person could not be detained for more than 10 days. 50 P.S. §41 (1923).

Significantly, a parent could not make an application on behalf of an allegedly mentally ill child without certification until 1966. 50 P.S. §4402, 4403 (1966). For confinement of a child more than 30 days, a court order was required as of 1961. Act of 20 September 1961, §304, P.L. 1527. Before that, the regular adult certification and court commitments were required.

Retarded children could be committed to the state institution for the feeble-minded upon parental application, but only after interrogatories were sworn under oath. Act of 3 June 1893, P.L. 291-292; Act of 15 May 1903, §§70, 13, P.L. 448. Ten years later, retarded adults and children became subject (as in 1836) to commitment as lunatics. Act of 25 July 1913, §10, P.L. 1322; Act of 12 June 1913, §13, P.L. 496; Act of 16 July 1919, §10, P.L. 987. In 1925, these procedures were altered so that only application and certification were used. Act of 27 April 1925, §2, P.L. 338.

Court Commitment. In 1869, the power to order confinement after a finding of lunacy by an inquisition was first incorporated into a statute. Act of 20 April 1869, P.L. 79-80 (hearing and notice required). Prior to 1869, the court did have the ability to confine where it was a question for the court whether restraint was proper. *Comm. ex rel. Nyce v. Kirkbride*, 2 Brewst. 400 (C.P. Phila. 1868); *Township of Franklin v. The Pennsylvania State Lunatic Hospital*, 30 Pa. 522 (1858)

(having been declared a lunatic by inquisition, a person unsafe to be at large could be subject to court proceedings). It was necessary to clarify this aspect of the law as, under the common law, a mere finding of "lunacy" did not mean automatic commitment to an institution. Court authorization was necessary for institutionalization of a lunatic. *Comm. ex rel. Draper v. Kirkbride*, 3 Brewst. 393 (C.P. Phila. 1869). Imbeciles could not be confined in a mental institution except pursuant to a court order or sworn certificate. *Comm. ex rel. Haskell v. Kirkbride*, 3 Brewst. 586 (C.P. Phila. 1869).

After a lunacy commission fulfilled its duties and reported to the court, the subject had the right to traverse the inquisition and proceed to trial on the issue. Act of 13 June 1836, §12, P.L. 594. The issue came to the court *de novo* and was to be tried by a jury. *Davidson v. Fry*, 11 Lanc. L. Rev. 357 (C.P. Lanc. 1892).[121]

A hybrid procedure was created in 1897 by statute. Act of 15 June 1897, §63, P.L. 162-163. Upon return of an inquisition, restraint of the person, or upon petition alleging restoration of sanity, the court had the duty to frame the issue and hold a jury trial under the common

[121]The issue to be tried on the traverse was whether a person's mind was so deranged as to disqualify him or her from conducting himself or herself with personal safety to self and others, and from managing and disposing of his or her own affairs and discharging his or her duties. *M'Elroy's Estate*, 6 W. & S. 451 (1843); *Commonwealth v. Meredith*, 14 Wkly Notes Cas. 188 (C.P. No. 2, 1884). Traverse was a common law proceeding originally for cases of idiocy *a nativate*. 2 Blackstone, *Commentaries on the Laws of England* 258; *McGinnis v. Comm. ex rel. McGinnis*, 74 Pa. 245 (1873).

law, if demanded. A verdict for the alleged lunatic was conclusive; a verdict against him or her was merely advisory. If no jury was demanded, the court would try the facts and issue a suitable order.

Summary and Conclusion. Beginning with the earliest colonial period of Pennsylvania history, through the Revolution and the state's first constitution, and continuing through the 19th Century and into the 20th Century, mental commitment has been a sovereign power strictly under the control and perogative of the state. Although procedures shifted and varied, any commitment to any institution, whether "public" or "private," was a matter of exclusive and paramount state concern and was, at all times and under all statutes, an action of the state. Mental commitment has never been simply a private matter.

Like education, elections, tax collection, fire and police protection, *Flagg Brothers, supra*, commitment of citizens to mental institutions in Pennsylvania has been a power "traditionally exclusively reserved to the state." *Jackson*, 419 U.S. at 352. Where parents or guardians, together with licensed institutions, deprive a person, of whatever age, of liberty, and label him or her mentally disabled, an action which is governmental in nature takes place.

In election cases, where political parties' activities are dictated by state law and where traditional state authority and functions are expressed through people who are not themselves government officials, state action is uniformly found. *See Nixon v. Condon*, 286 U.S. 73 (1932); *Gray v. Sanders*, 372 U.S. 368 (1963); *Anderson v. Martin*, 375 U.S. 399 (1964). *See also,*

Norwood v. Harrison, 413 U.S. 455 (1973) (intertwined educational function and unconstitutional practices). Here, the licensed institutions' commitment activities are dictated by state law and traditional state exclusive authority and functions are implicated when people are confined in such places. The result, a finding of state action, must be the same. There is "a sufficiently close nexus between the State and the challenged action of the regulated entity so that the action of the latter may be fairly treated as that of the State itself." *Jackson*, 419 U.S. at 351.

III.

THE DISTRICT COURT DID NOT ABUSE ITS DISCRETION IN CERTIFYING PLAINTIFF SUBCLASSES AND A DEFENDANT CLASS.

A. The Plaintiff Subclasses.

Pursuant to this Court's remand, the District Court exhaustively re-examined the plaintiff class issues (1065a-1076a) and certified two plaintiff subclasses, one of "all juveniles committed as mentally ill . . . who are under the age of fourteen" and the other of "all juveniles committed as mentally retarded . . . who are age eighteen or younger." (1089a). The defendants object in this Court on two grounds. "The first is the lack of representation for those of tender years in the class." Brief for Appellants at 55. The second is that "those who have been admitted for long term care cannot adequately represent the interests of those who have not." *Id.* at 56-57.

These objections were not raised below and should not be considered here for the first time. These objections have been belatedly inserted into the case for this appeal. They were not raised in the Answer to the Amended and Supplemental Complaint. *See* 917a (Par. 10) and 925a. They were not raised in Defendants' Response to Plaintiffs' Motion for Class Action (941a).[122] These objections were neither made nor briefed in the lower court before judgment was entered. Defendants should not be permitted to sit silent through litigation, and give no hint of any opposition to proposed plaintiff subclasses, and then to claim error for the first time on appeal. Absent any abuse of discretion by the lower court in deciding the issues, this Court should not consider these objections on appeal.

On their merits, the objections must be rejected. After careful and reflective analysis of factors affecting commitment rights of the mentally ill and the mentally retarded, the District Court turned to the "tender years" consideration and held that "the need for due process protection and the factors which this Court must consider in determining what process is due, are the same for older and younger retarded juveniles." (1071a). The "same factors hold true irrespective of the child's age." (1070a) (detailing the factual context).[123]

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[122] Another unrelated objection, not raised on appeal, was presented (917a, 941a).

[123] Although the three retarded plaintiffs were over thirteen when suit was filed, all were committed before they reached thirteen and when they were not subject to the 1973 regulations. Nothing in the record indicates they ever received notice of any additional rights at any time after their thirteenth birthday (Opinion at 1075a, 1076a, n. 43). For these reasons, they may appropriately represent the under-thirteen retarded commitments. Also, as the lower court explained, "if the statutory scheme is unconstitutional with respect to the older juveniles who receive greater protections, then it is *a fortiori* unconstitutional with respect to the younger juveniles who receive far less protection." (1075a).

For those committed as mentally ill, the class was also found "cohesive and free from conflict," "irrespective of that child's age." (1073a). With absolutely nothing in the record to support this objection,[124] and absent any abuse of discretion, it must be rejected. Plaintiffs joined in class litigation "to assert a common right," *Hansberry v. Lee*, 311 U.S. 32, 44-45 (1940), and to challenge a state statute on constitutional grounds. In this circumstance, plaintiff subclasses including all ages of juveniles with common legal and factual connection with the statute are proper. *See Washington v. Lee*, 263 F.Supp. 327 (M.D. Ala. 1966), *aff'd*, 390 U.S. 333 (1968).[125]

[124]On the retarded, it is noted again that the defendants chose not to introduce any testimony at all; the only testimony on the retarded rebuts any age differences relevant to this case. On mental health commitments, defendants' only references to the record fail to support their claims. *See* Brief for Appellants at 56, n. 54.

[125]Mental commitment cases are regularly decided as class actions. *See, e.g., Rakes v. Coleman*, 318 F.Supp. 181 (E.D.Va. 1970); *Anderson v. Solomon*, 315 F.Supp. 1192 (D.Md. 1970); *Meisel v. Kremens*, 405 F.Supp. 1253 (E.D.Pa. 1975); *Goldy v. Beal*, 429 F.Supp. 640 (M.D. Pa. 1976). Where four plaintiffs sought to invalidate a sexual psychopath statute, a class was upheld with the three-judge court observing:

> Allowing a class action is further warranted because, where plaintiffs seek not to collect monetary damages but to strike down a constitutionally offensive statute, the requested relief (if granted) will necessarily affect all persons subject to the statute—whether formally combined as a class or not.

Davy v. Sullivan, 354 F.Supp. 1320, 1325 (M.D. Ala. 1973). *See* 4 *Newberg on Class Actions* §7942h, at 156 (1977). *See also Gesicki v. Oswald*, 336 F.Supp. 371, 374 (S.D.N.Y. 1971) (class attack by juveniles on "wayward minor" commitment law).

Defendants' second objection seeks to distinguish among young persons committed to an institution for "relatively long term care" and others who receive "no more than two or three weeks of in-patient care in a public or private facility." Brief for Appellants at 56.[126] Of course, all class members committed to institutions, even for a short time, are subject to deprivation of liberty, stigma and other risks (e.g., 1023a), all pursuant to the challenged statutes. The balancing suggested here by the defendants has already been accomplished by the lower court's allowance of a three day detention for emergency purposes and two week detention after a probable cause hearing. Class members need not be exact replicas of one another.[127]

B. The Defendant Class

In both the original proceedings and on remand, this litigation proceeded against a defendant class of institutional directors and discovery was had against all inpatient residential mental institutions in Pennsylvania. Defendants objected on remand to the defendant class, apparently on the grounds that a commonality of interests is lacking among the class members and that the defendant representatives are unable to adequately defend the interests of the class members. Brief for Appellants at 57 (Appellants never

[126]Defendants also refer to minors in community-based small family-like group homes. As explained previously, *supra* note 51, this case has nothing to do with such non-institutional facilities.

[127]Opinion at 1076a, n. 43. *See, Carpenter v. Davis*, 424 F.2d 257 (5th Cir. 1970); *Jones v. Milwaukee County*, 20 F.R.Serv.2d 1339 (E.D.Wis. 1975); *Sullivan v. Houston Independent School District*, 307 F.Supp. 1328, 1337-1338 (S.D. Tex. 1969).

briefed this issue in the lower court; their only reference to the issue is a statement of it at 941a).

The defendants presented no evidence at trial on any alleged "lack of common interests."[128] In fact, as discussed *supra* at n. 11, several licensed facilities were represented by counsel at the March 31, 1978 Final Hearing; they did not object to going forward at that time, they did not seek to present any evidence, and they did not object to the Attorney General representing their interests. They filed no motions with the lower court at any time, but did file amicus briefs after trial.

Notwithstanding the passivity of the defendants, the District Court carefully considered the question and, in its separate memorandum opinion (956a *et seq.*) and the final opinion (1071a, n. 37) rejected the challenge.

Where a state-wide class of diverse local entities caring for children is sued, and where each, as a practical matter and by operation of state law, would be bound by the result, a defendant class is appropriate. *Pennsylvania Association for Retarded Children v. Commonwealth of Pennsylvania*, 343 F.Supp. 279 (E.D. Pa. 1972) (Three-Judge Court) (retarded children sued all local school districts in Pennsylvania; as here, Attorney General properly represented the local interests throughout the litigation). *See also Samuel v. University of Pittsburgh*, 56 F.R.D. 435 (W.D. Pa. 1972) (defendant class of various institutions of higher learning across Pennsylvania).

[128] After entry of judgment, at the hearing on the stay, one state witness made some self-serving general references to licensed facilities in the context of implementation questions. The lower court never had occasion to consider the question with regard to the class issue and the defendants never asked the lower court to consider the question on the basis of any briefs or evidence.

Where inmates challenge a state statute and sue a defendant class of facility directors whose duty it is to implement the law, the class is upheld although the physical plants of the institutions across the state may vary and although, but for the challenged statute, the defendants may not be identically situated. *Washington v. Lee*, 263 F.Supp. 327 (M.D. Ala. 1966), *aff'd*, 390 U.S. 333 (1968) (defendant class of wardens, jailors, and sheriffs state-wide).

Just and complete litigation is possible, as here, without redundant parties who would simply add to the papers and pleadings and fill the courtroom with lawyers and witnesses without illuminating the issues at stake.[129]

The lower court's certification of the defendant class was correct and not an abuse of discretion.

[129] There are more than 400 state-licensed mental institutions in Pennsylvania (957a). For similar and analogous defendant class actions, *see, e.g., Rakes v. Coleman*, 318 F.Supp. 181 (E.D. Va. 1970) (defendant class of all state court judges empowered to order commitment); *Kendall v. True*, 391 F.Supp. 413 (E.D. Ky. 1975) (mental health commitments; defendant class of all Jefferson County judges); *Danforth v. Christian*, 351 F.Supp. 287 (W.D. Mo. 1972) (defendant class of persons enforcing vote residence requirements); *Congress of Ry. Unions v. Hodgson*, 326 F.Supp. 68 (D.D.C. 1971) (nationwide case; defendant class of railroads).

IV.

THE DISTRICT COURT DID NOT ERR IN REQUIRING THE DEFENDANTS TO ASSURE THAT YOUNG PERSONS PRESENTLY COMMITTED RECEIVE CONSTITUTIONAL STATE PROCEDURES TO DETERMINE WHETHER THEY ARE MENTALLY DISABLED AND IN NEED OF INSTITUTIONALIZATION.

The complaint herein requested injunctive and declaratory relief to assure constitutional state procedures in the commitment of young persons to mental institutions. Seeking only the guarantee of a state forum in which to have the claims against them determined, the plaintiffs sought from the federal court neither release nor any order with regard to their custody.

The District Court declared the plaintiffs' commitments invalid and ordered the defendants to initiate procedures to assure that all juveniles committed without hearings or counsel under the unconstitutional statutes receive the benefit of the minimal due process protections discussed above. Any hearings which might result would be in a forum created by the state.[130]

Appellants' assertion that *Preiser v. Rodriguez*, 411 U.S. 475 (1972), and *Wolff v. McDonnell*, 418 U.S. 539 (1973), bar such relief is based on a misreading of those cases and a failure to note other actions of this Court

[130]Defendants do not object to any of the declaratory relief granted. Their sole objection on this issue is to the prospective injunction at Par. 18C of the Order (1099a).

which support the District Court's order.

Preiser and *Wolff* held that litigants could not obtain from the federal courts, in actions under 42 U.S.C. §1983, relief affecting "the fact or duration of confinement" or effecting "immediate or a speedier release." *Preiser*, 411 U.S. at 500. *Wolff* noted that "an injunction restoring good time improperly taken is foreclosed" but specifically permitted federal courts to "fashion appropriate remedies for any constitutional violations ascertained, short of ordering the actual restoration of good time already cancelled." 418 U.S. at 555.

The District Court faithfully followed *Wolff's* proscription. It did not order "actual restoration" of liberty to plaintiffs and their class; it simply ordered that the defendant officials assure that proper state proceedings be afforded persons who have never had them. It would be in these state proceedings (not in the federal court) that commitment determinations would take place. The alternative to this orderly process would have been to allow the possibly erroneous commitment of thousands of persons to stand.

This Court's decision in *Gerstein v. Pugh*, 420 U.S. 103 (1975), directly supports the District Court and explains the error in appellants' argument:

> Respondents did not ask for release from state custody, even as an alternative remedy. They asked only that the state authorities be ordered to give them a probable cause determination. This was also the only relief that the District Court ordered for the named respondents. 332 F.Supp. at 1115-1116. Because release was neither asked nor ordered, the lawsuit did not come within the class of cases for which habeas corpus is the exclusive remedy. *Preiser v. Rodriguez*, 411 U.S.

475, 93 S.Ct. 1827, 36 L.Ed.2d 439 (1973); see *Wolff v. McDonnell*, 418 U.S. 539, 554, 94 S.Ct. 2963, 2973, 41 L.Ed.2d 935 (1934).

Id. at n. 6.[131] *See Gomez v. Miller*, 341 F.Supp. 323 (S.D.N.Y. 1972), *aff'd sub nom. Miller v. Gomez*, 412 U.S. 914 (1973) (class action challenging constitutionality of pretrial confinement in state mental institution for the criminally insane; relief sought and upheld was a state "determination of dangerousness as a prerequisite to retention"); *Goldy v. Beal, supra* note 125.

Appellants' reliance on *Kendall v. True*, 391 F.Supp. 413 (W.D. Ky. 1975), is misplaced. That case did not consider or discuss the *Preiser* issue. Also, the plaintiff mental patients in *Kendall* were incarcerated under a statute which provided for a maximum term of 60 days and under which a judicial hearing and counsel were provided. Here, the plaintiffs are under indeterminate commitments and have had no counsel or hearing.

Defendants further argue that, if it is held that those plaintiffs covered by paragraph 18C of the order must utilize habeas corpus, the exhaustion requirements of 28 U.S.C. §2254(b) would apply. However, §2254(b) applies only to "persons in custody pursuant to the judgment of a state court."[132] Plaintiffs were all

[131] In *Gerstein*, as in this case, persons were deprived of their liberty for substantial periods without probable cause hearings. The relief granted in *Gerstein*, as in this case, assured constitutional procedures in a state forum.

[132] If plaintiffs' §1983 claims went "directly" to the propriety of their confinement and also sought from the federal court either "immediate release" or a "shortening" of confinement, then under *Preiser* they would be fatally "close to the core of habeas corpus" even though they are not in custody under a state court

(continued)

committed without any involvement of a state court or other adjudicatory body whatsoever. There is no state corrective process available and effective to protect the plaintiffs' rights; no exhaustion of remedies is required because there are none to exhaust.[133]

Principles of federalism were similarly respected by the District Court. No state proceedings were interfered with; in fact, the state executive, judicial and legislative branches are left free to continue commitment of young persons, so long as the procedures used do not violate the Constitution.

CONCLUSION

For the above reasons, it is respectfully submitted that the Court should affirm once more that the Constitution is not for adults alone and that the massive curtailment of liberty inherent in mental institutionalization necessitates substantial procedural protections under the Due Process Clause of the Fourteenth Amendment. The judgment below should be affirmed.

Respectfully submitted,

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Counsel for Appellees

(footnote continued from preceding page)
judgment. *Preiser*, 411 U.S. at 849. However, where no such relief is sought or obtained, and where the state forum will decide the propriety of individual's confinement, the literal terms of the statute apply.

[133] Habeas corpus in state court is of no avail. The damage of commitment is already done by the time a child is likely to have the opportunity to consider such an avenue. If a child—without counsel or other representative—has the wherewithal to file a petition, any relief is too little, too late.